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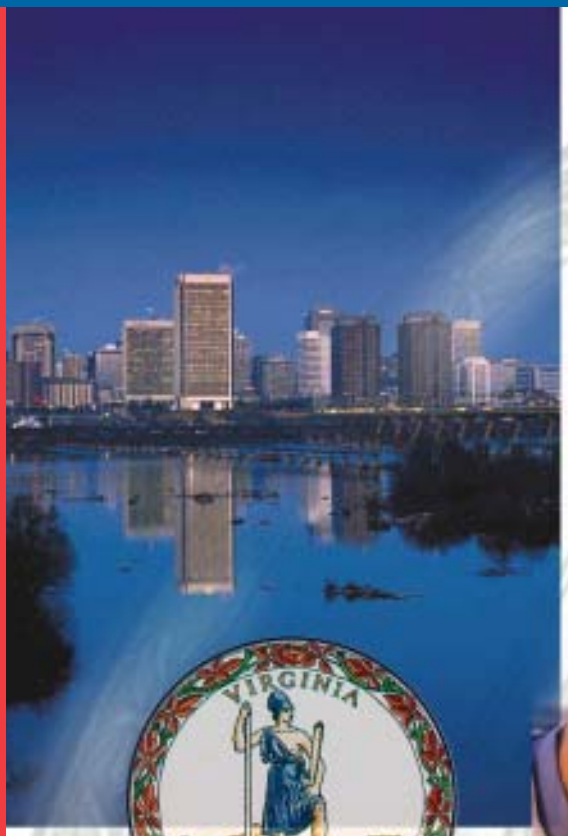

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Optima Family Care

CY 2005

We don't provide healthcare... we make it better.

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Optima Family Care – Operational Systems Review

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This annual report will include the overall results of the Operational Systems Review as well as the findings related to quality, access and timeliness of care.

The Operational Systems Review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva evaluated the following systems:

- Enrollee Rights and Protections (ER) —Subpart C Regulation
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems (GS)—Subpart F Regulation

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva conducted a comprehensive review of Optima Family Care to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services using the results of the Operations Systems Review.

The results of the OSR are contained in this report and are first analyzed by standard (Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance Systems). After this analysis, performance on these standards are assessed relative to quality access and timeliness of services provided to the MCO's members. Strengths and opportunities for improvement are also identified for use in further quality improvement efforts. It is expected that each MCO will utilize the review findings and recommendations found in this report to implement operational systems improvement to become fully compliant with all standards and requirements.

Background on Plan

Optima provides managed care services to Medallion II enrollees in various localities throughout the state of Virginia. Enrollment in December 2005 for Optima health plan was 12,389 members. Localities covered by Optima are Tidewater, Central Virginia, Charlottesville, and Halifax regions. Optima began providing services to Medallion II enrollees in January 1996 and are an NCQA-accredited health plan with an excellent accreditation status.

Data Sources

Delmarva used many data sources to assess compliance with the operational systems standards. Information was requested from the MCO and reviewed by Delmarva prior to the on-site review. At the time of the on-site review additional data were collected through staff interviews and review of additional documents and systems. Data sources include, but are not limited to:

- Policies and Procedures
- Interviews with MCO staff
- Credentialing Files
- Complaint, Grievance and Appeals Files
- Committee Meeting Minutes (Quality, Credentialing, and Utilization Management)
- Member Materials
- Provider Manuals and Materials
- Internal MCO Staff Training Information
- Quality Improvement Projects
- Focused Studies
- Annual Quality and Utilization Management Program Evaluations

Methodology

The Optima Family Care (OFC) Operational Systems Review assessed activities performed by the MCO during the time frame of January 1, 2005 through December 31, 2005 (CY 2005). The purpose was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The

review incorporated regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq.* In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights (ER) and Protections—Subpart C Regulation.
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation.
- Grievance Systems (GS)—Subpart F Regulation.

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

The operational systems standards used in the calendar year (CY) 2005 review were the same as those used in the 2004 review period (January 1, 2004-December 31, 2004) and in the 2003 review period (June- December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "unmet." Each element that was not fully met in the 2003 review was assessed as part of the calendar year (CY) 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or unmet in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO' had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified. The CY 2005 review included a review of all operational systems standards as in prior reviews and was conducted on-site at the MCO as in the 2003 review.

Consistent with all prior reviews, Delmarva staff completed the review using all information provided by the MCO which included, but is not limited to policies, procedures, interviews, review of complaint, grievance appeals, and credentialing files. Each element within a standard was rated as "met," "partially met," or "unmet". Elements were then rolled up to create a determination of "met", "partially met", or "unmet" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met.
Partially Met	At least half the required elements within the standard were met or partially met.
Unmet	Less than half the required elements within the standard were met or partially met.

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. In CY 2005, all standards were reviewed as in the 2003 review. This provides the DMAS with a current evaluation of the processes that have been developed, implemented, and/or remain in place since the 2003 evaluation.

The results of the OSR are then applied to the categories of quality, access, and timeliness of services for a final analysis.

Results by System

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2005 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Met
Subpart D- Quality Assessment and Performance Improvement	Partially Met
Subpart F- Grievance Systems	Met

A total of 47 standards are evaluated as part of the Operational Systems Review. All seven (7) Enrollee Rights standards were fully met. Of the 29 Quality Assessment and Performance Improvement standards, 28 were met and only one was unmet. All of the 11 Grievance Systems standards were met.

Results for each of the 47 Operational Systems Review elements contained within each of the three standards are presented in Table 3.

Table3. 2005 Operational Systems Review Results for Optima Family Care.

Standard Number	Standard Description	Element Ratings Met/Partially Met/Unmet	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	11/0/0	Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	14/0/0	Met
ER 3	Information and language requirements	8/0/0	Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	5/0/0	Met
ER 6	Advanced directives	5/0/0	Met
ER 7	Rehabilitation Act, ADA	3/0/0	Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met
QA 5	Cultural considerations	1/0/0	Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met
QA 8	Direct access to specialists	3/0/0	Met
QA 9	Referrals and treatment plans	1/0/0	Met
QA 10	Primary care and coordination program	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	2/0/0	Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	0/0/1	Unmet
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Unmet	Standard Rating
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	1/0/0	Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	3/0/0	Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	8/0/0	Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	1/0/0	Met
GS 4	Content of notice action	6/0/0	Met
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met
GS 9	Resolution and notification	3/0/0	Met
GS 10	Requirements for state fair hearings	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 standards, by element are found in Appendix I-A2.

Results by Outcome

Quality, Access and Timeliness

This portion of the annual report provides an evaluation by Delmarva, as the EQRO to assess the progress that Medallion II managed care plans have made in fulfilling the goals of DMAS related to quality, timeliness, and access. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

Although Delmarva's task is to assess how well Optima Family Choice performs in the areas of quality, access, and timeliness from the operational systems review perspective, it is important to note the interdependence of quality, access, and timeliness. Therefore, a measure or attribute identified in one of the categories of quality, access, or timeliness also may be noted under either of the two other areas.

Quality, access, and timeliness of care are expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report. An analysis by quality, access, and timeliness follows.

Quality

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population.

In regards to quality, OFC performed well in the areas of enrollee rights, quality assurance and performance improvement, and grievance systems. Specifically in regards to the Enrollee Rights system, OFC has the required enrollee rights and responsibilities in place. Provider-enrollee communications are encouraged and not limited by the MCO. The OFC Member Guide describes all required benefits and services. Referral and authorization processes are in place and are monitored for timeliness. Members with special needs are allowed to have a specialist as their PCP and members can receive a second medical opinion at no cost. Compliant, grievances and appeals process are in place and appear to be functioning well. All of the standards for information and language requirements were met. Documentation was provided that readability requirements for member materials were met and interpretation and translation services are available. Adequate policies and procedures are in place to address enrollee confidentiality as required by HIPAA.

In the Quality Assessment and Performance Improvement standards, OFC also performed well. A case management program is in place to manage those members with certain high-risk conditions or needs. Continuity and coordination of care policies and procedures are in place for both physical and behavioral health. The credentialing and recredentialing process is comprehensive. Delegation policies and procedures are in place. Pre-delegation activities occur and there is monitoring of all delegates at least annually. OFC has preventive and disease specific clinical practice guidelines in place. The process to develop, implement, disseminate, and review guidelines is well established.

Processes are in place to monitor over and under utilization of services and use of technology protections-staff/provider, cultural considerations, dissemination of practice guidelines, basic elements of QAPI program, health/management information systems, and content of notice of action. Policies and procedures were revised for compliance in the areas shown above. An example of a significant area where Optima has performed successfully in this review is with cultural considerations.

In the last review, OFC was found to have opportunities for improvement in the areas of coverage and authorization of services, grievance systems and, notice of action. For coverage and authorization of services relating to the monitoring of the application of review criteria for authorizations and taking corrective action to ensure consistent application; a recommendation was provided. In the CY 2005 review, it was concluded that health care professionals with the appropriate credentials are used to make utilization management decisions. Inter-rater reliability testing is conducted monthly in the areas of adherence to medical care policies, coding appropriateness, and policies requiring Medical Director authorizations. This addressed the concern identified in the CY 2004 review.

The Grievances System standards were all met. The notices of action and appeals packets provide members with all required information related to State Fair Hearings. Standards for resolving complaints, grievances, and appeals are in place and are monitored for timeliness. Expedited processes are in place to ensure timely decisions when there are extenuating circumstances.

Optima demonstrates a quality-focused approach in administering care and services to its members. The plan exhibits an integrated approach to working with its members, practitioners, providers, and internal health plan departments to improve overall health care quality and services. All Quality Assessment and Performance Improvement standards were met in 2005, except for one related to the provider anti-discrimination policy. This policy has already been modified in 2006 to address this deficiency.

Access

Access is an essential component of a quality-driven system of care, and historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings related to access are assessed through the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance Systems standards as described below.

In the CY 2004 review, Optima performed well in the areas of information and language requirements, emergency and post-stabilization services, and availability of services. It was also noted that policies and procedures were revised prior to this review to ensure compliance within these areas. These standards remain met for the CY 2005 review.

OFC continues to perform well in the areas of information and language requirements. Optima has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. OCF provides an in-home member education session for members who are visually impaired and a closed-captioned member education video for those who are hearing impaired.

Members are ensured access to various services through policies and procedures. Specifically, members have access to out-of-network and out-of-area services. Female members are allowed to obtain an annual gynecological examination ad well as confidential family planning and birth control services from any participating provider without a referral. Finally, enrollees have access to a second opinion from a qualified health care professional at no cost to the enrollee. OFC also has a comprehensive set of member confidentiality and protected health information policies that meet DMAS and HIPAA requirements.

Optima has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed. Optima has policies that allow

enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their primary care provider (PCP) be a specialist.

In the last review, a recommendation was provided for changes to member information, language requirements, and policies related to the Rehabilitation Act. It was recommended that OFC revise its policies to include procedures for informing enrollees about the availability of alternative formats for MCO information with instructions on how to obtain those formats. Optima submitted a revised Interpreter and Translation Services policy in CY 2005 that addressed this recommendation.

Overall, access is an area of strength for Optima and supports the health plan's intent as a quality-driven system of care. Optima addressed the areas where it showed vulnerability and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Timeliness

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. Delmarva assessed the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance System standards to evaluate Optima's commitment to timeliness of services.

In general, OFC performed well in the areas of coverage and authorization of services, resolution and notification for grievances and appeals, and provision of information to members regarding State Fair Hearing timeliness requirements. Timeframes for completion of grievances and appeals are consistent with requirement. The Services Requiring Authorization and Timeframes for Decisions policy outline all of the required decision timeframes and monitoring efforts. OFC performed well on the timeliness measures. An expedited authorization process is in place to allow members with special circumstances to receive an expedited decision.

In the CY 2004 review, it was recommended that OFC revise the Services Requiring Authorization and Timeframes for Decisions policy to include the extension time frame for expedited authorizations provided in the Medallion II Managed Care Contract. A revised Services Requiring Authorization and Timeframes for Decisions policy was subsequently submitted and now meets the requirement for this standard.

OFC demonstrates an awareness of the importance of timeliness in the delivery of overall quality care and service through the identification of timeliness barriers, which often are identified as access issues. OFC

continues to incorporate recommendations made by Delmarva that have resulted in the MCO meeting all standards related to timeliness of care.

Overall Strengths

Quality:

- Provider-enrollee communications are encouraged and not limited by the MCO.
- A case management program is in place to manage those members with certain high-risk conditions or needs.
- Continuity and coordination of care policies and procedures are in place for both physical and behavioral health.
- The credentialing and recredentialing process is comprehensive.
- Health care professionals with the appropriate credentials are used to make utilization management decisions.
- Delegation policies and procedures are in place. Pre-delegation activities occur and there is monitoring of all delegates at least annually.
- Clinical practice guidelines are in place. The process to develop, implement, disseminate, and review guidelines is well established.
- Inter-rater reliability testing is conducted monthly in the areas of adherence to medical care policies, coding appropriateness and policies requiring Medical Director Authorization.
- Processes are in place to monitor over and under utilization of services and use of technology.

Access:

- The OFC Member Guide is comprehensive and includes all required information to ensure member access to benefits and services.
- All required access standards and mechanisms to monitor these standards are in place.
- Processes are in place to ensure member access to out-of-network and out-of-areas services.
- Enrollment and disenrollment policies and procedures are in place.
- Policies and procedures are in place to ensure that members who are non-English speaking, have limited English proficiency or who have special needs (e.g. visual impairments) have vital documents translated, have access to interpretation and translation services, and have information provided at the appropriate reading level.
- Access to protected health information (PHI) and member confidentiality is appropriately controlled through internal policies and procedures that are in compliance with HIPAA regulations.
- Policies and procedures are in place for members to access emergency and post-stabilization services.
- Members are ensured access to care 24 hours per day, seven days per week. Access is monitored at least annually to ensure PCP compliance.

- Enrollees have access to a second opinion from a qualified health care professional at no cost to the enrollee.
- Female members are allowed to obtain an annual gynecological examination ad well as confidential family planning and birth control services from any participating provider without a referral.
- Enrollees with special needs can have a specialist as their PCP.

Timeliness:

- The pre-authorization policies and procedures address timeliness of decisions. There are processes in place to monitor timeliness of decisions.
- The Services Requiring Authorization and Timeframes for Decisions policy outline all of the required decision timeframes and monitoring efforts.
- An expedited authorization process is in place to allow members with special circumstances to receive an expedited decision.
- The grievance system is established and appears to be functioning well. Timeframes for completion of grievances and appeals are consistent with requirements and are monitored for compliance to these standards.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for Optima Family Choice are as follows:

The Network Composition Policy did not meet the provider non-discrimination requirements in regards to providers serving high-risk populations or those specializing in conditions that require costly treatment. The policy was revised in 2006 to meet this expectation. Therefore, it is recommended that OFC ensure that these specific non-discrimination requirements remain in the policy in any subsequent revisions.

References

Centers for Medicare and Medicaid Services (CMS). (2002, June). *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et.al., Subpart D- Quality Assessment and Performance Improvement.* Retrieved December 9, 2004, from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf

Centers for Medicare and Medicaid Services (CMS). (2003, January). *Final Rule: External Quality Review of Managed Care Organizations and Prepaid Inpatient Health Plans; 42 CFR Part 438.300 et.al.* Retrieved November 1, 2004 from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/eqr12403.pdf

Institute of Medicine (IOM), Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. (2001). *Envisioning the National Health Care Quality Report.* Retrieved February 24, 2005, from the National Academies Press website: http://www.nap.edu/html/envisioning/ch2.htm

National Committee for Quality Assurance (NCQA). (2003). *Standards and Guidelines for the Accreditation of* MCOs.

Appendix IA1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.	X			
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.	X			
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.	X			
2.13	Procedures to share information with enrollees that they are not liable for payment in the case of MCO insolvency.	X			
2.14	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10).					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.	X			
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	X			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	X			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	X			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	X			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	X			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	X			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	X			
ER6. Advanced Directives.					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	X			
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	X			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	X			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.	X			
ER7. Rehabilitation Act, ADA.					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.	X			
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA1. 438.206 Availability of services (b).					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	X			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	X			
QA2. 438.206 Availability of services (b)(2).					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	X			
QA3. 438.206 Availability of services (b)(3).					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	X			
QA4. 438.206 Availability of services (b)(4).					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations.					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care.					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs.					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans.					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	X			
QA10. 438.208(e) Primary Care and Coordination Program.					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests.					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action.					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions.					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	X			
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination.					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.			X	To receive a determination of met in future reviews, OFC must ensure that the Network Composition Policy, as revised in January 2006, continues to include the policies and procedures that ensure the MCO will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
QA17. 438.12 (a, b) Provider discrimination prohibited.					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers.					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO.					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee.					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems.					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation.					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines.					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals and	X			
d)	Are reviewed and updated periodically, as appropriate.	X			
QA24. 438.236 (c) Dissemination of Practice Guidelines.					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines.					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program.					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems.					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. accepting and processing enrollment b. Reconciling reports of MCO enrollment/eligibility c. Accepting and Processing provider claims and encounter data d. Tracking provider network composition, access to services, grievances and appeals e. Performing QI activities	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data b. Screening the data for completeness, logic, and consistency c. Collecting the service information in standard formats for DMAS d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System.					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures.					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action.					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements.	X			
GS4. 438.404 (b) Content of Notice Action Content of NOA explains all of the following:					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements.					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	X			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	X			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution.					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	X			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	X			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals.					
8.1	MCO has an expedited appeal process.	X			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	X			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification.					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings.					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions.					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Appendix IA2 - Detailed Findings

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.

Element 1.1 – Enrollee rights and responsibilities.
This element is met.

The Optima Family Care (OFC) Member Rights and Responsibilities Policy contains a detailed description of the member rights and responsibilities. According to the policy, the Member Rights and Responsibilities statement is included in the MCO's Enrollment Guide and made available to each new member of OFC. The statement is also included in the OFC Member Guide and is made available at all participating primary care provider offices through the OFC Provider Manual.

Element 1.2 – Out-of-area coverage.
This element is met.

The Out of Area/Out of Network Services Policy describes the process by which members may obtain out-of-area and out-of-network services. The policy states that all out-of-area and out-of-network care must be reviewed by OFC's Case Management Department prior to medical necessity authorization. The policy further states that services that are not available by an appropriately trained in-network provider will reviewed by Medical Care Management for authorization to an appropriate provider. The procedures for obtaining out-of-area and out-of-network services are communicated to members in the Member Guide.

Element 1.3 – Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is met.

The Member Guide states that members must chose their primary care providers (PCPs) from a list of participating providers that includes family practitioners, internists, OB/GYNs, and pediatricians. Any member with a disability, chronic illness, or special concerns may contact OFC Member Services to have a specialist assigned as his or her PCP. The Family Planning Policy states that OFC members may obtain confidential family planning and birth control services from any participating provider without a referral from their PCPs. This information is communicated to members through the Member Guide.

The MCO's policy is expressed in the Member Guide. The Member Rights and Responsibilities Policy also includes the right of members to select their own PCPs and expect the physician to provide or arrange for, and coordinate, all care they require.

Element 1.4 – Referrals to specialty care (422.113c).
This element is met.

The Member Guide states that members receive specialty care through referrals made by their PCPs. The Services Requiring Authorization and Timeframes for Decisions Policy outlines the specialty care services that require preauthorization and those that do not.

Element 1.5 – Enrollee notification – termination/change in benefits, services or service delivery site.
This element is met.

The PCP/Specialist/Provider Site Termination Notification to Members Policy outlines OFC's procedures for notifying members when PCPs and specialists are terminated from the provider network. The policy specifies the conditions under which members may have continued access to terminated providers and describes the process for assigning new PCPs, specialists, and provider sites to members affected by provider terminations. Members are notified of provider terminations in writing at least 30 days prior to the effective date whenever possible.

Element 1.6 – Procedures that instruct how to contact enrollee services and a description of the department and its functions.
This element is met.

The Member Guide states that OFC's Member Services Department is available to members Monday through Friday from 8:30 a.m. to 5:00 p.m. and can be reached by local and toll-free telephone numbers during these hours. The department also has separate local and toll-free telephone numbers for hearing-impaired members. The Member Services Department may be contacted to answer questions or concerns about the MCO, provide assistance in changing PCPs, and provide assistance with member benefit issues, inquiries, problems, or complaints. The procedures are expressed in the Member Guide.

Element 1.7 – Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is met.

OFC maintains multiple policies and procedures for resolving complaints and appeals. These include the

Member Complaint Procedures, Standard Appeal Procedures, and the Expedited Appeal Procedures policies. These policies and procedures address the fair hearing process for the State of Virginia Department of Medical Assistance Services (DMAS) and are communicated to members in the Member Guide.

Element 1.8 – List of non-English languages spoken by which contracted provider.
This element is met.

The Interpreter and Translation Services Policy states that providers who speak languages other than English can be selected by accessing the Find a Doctor tool at www.optimahealth.com. This website can be accessed directly by members or they may contact the Member Services Department for assistance.

Element 1.9 – Provider-enrollee communications.
This element is met.

The Member Rights and Responsibilities Policy states that members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. The policy further states that members have the right to discuss their medical records with their physicians.

Element 1.10 – Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

The Insolvency of MCO Policy states that language holding members harmless for payment in the case of MCO insolvency is included in the Evidence of Coverage (EOC) section of the Member Guide. A review of the Member Guide confirmed the presence of this language.

Element 1.11 – Enrollment/ Disenrollment.
This element is met.

The File Uploads and Reports Policy describes the procedures used to enroll members into and disenroll members from the MCO. These procedures are also described in the Member Guide and include how to enroll newborns.

ER2. Upon enrollment and according to expected time frames, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 – Enrollee rights and responsibilities.
This element is met.

The Member Rights and Responsibilities Policy contains a detailed description of the member's rights and responsibilities. According to the policy, the Member Rights and Responsibilities statement is included in the MCO's Enrollment Guide and made available to each new member of OFC. The statement is also included in the OFC Member Guide and is made available at all participating primary care provider offices through the OFC Provider Manual.

Element 2.2 – Enrollee identification cards – descriptions, how and when to use cards.
This element is met.

The Member Guide states that every OFC member is provided with an identification card. Members are directed to always show their ID cards whenever they receive medical or mental health care services and are warned that allowing someone else to use their card may result in cancellation of their membership in the MCO and/or criminal prosecution. The ID card includes the member's name and ID number, the member's effective date with the MCO, the name of the member's PCP, the Member Services Department telephone numbers, and the After Hours Nurse Triage telephone numbers.

Element 2.3 – All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is met.

The Services Requiring Authorization and Timeframes for Decisions Policy outlines the specialty care services that require preauthorization and those that do not. The Member Guide includes an EOC section detailing covered services with exclusions and limits placed on them and details how services may be obtained outside the OFC system. The Member Guide is provided to enrollees upon enrollment.

Element 2.4 – Procedures for obtaining out-of-area coverage.
This element is met.

The Out of Area/Out of Network Services Policy describes the process by which members may obtain out-of-area and out-of-network services. The procedures for obtaining out-of-area and out-of-network

services are communicated to members in the Member Guide, which is mailed to members after enrollment.

Element 2.5 – Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is met.

The Member Guide states that members chose their PCPs from a list of participating providers that includes family practitioners, internists, OB/GYNs, and pediatricians. Any member with a disability, chronic illness, or special concerns may contact OFC Member Services to have a specialist assigned as his or her PCP. The Family Planning Policy states that OFC members may obtain confidential family planning and birth control services from any participating provider without a referral from their PCPs. This information is communicated to members through the Member Guide, which is provided to members after enrollment.

Element 2.6 – The MCO's policy on referrals for specialty care.
This element is met.

The Member Guide states that members may access and receive specialty care through referrals made by their PCPs. The Services Requiring Authorization and Timeframes for Decisions Policy outlines the specialty care services that require preauthorization and those that do not. The Member Guide includes a section on the benefits offered by OFC and details whether particular services require authorization before they can be accessed and provided.

Element 2.7 – Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is met.

The PCP/Specialist/Provider Site Termination Notification to Members Policy outlines OFC's procedures for notifying members when PCPs and specialists are terminated from the provider network. The policy specifies the conditions under which members may have continued access to terminated providers and describes the process for assigning new PCPs, specialists, and provider sites to members affected by provider terminations. Members are notified of provider terminations in writing at least 30 days prior to the effective date whenever possible. Language reflecting this policy is documented in the Member Guide, which members receive upon enrollment.

Element 2.8 – Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is met.

The Member Guide states that OFC's Member Services Department is available to members Monday through Friday from 8:30 a.m. to 5:00 p.m. and can be reached by local and toll-free telephone numbers during these hours. The department also has separate local and toll-free telephone numbers for hearing-impaired members. The Member Services Department may be contacted to answer questions or concerns about the MCO, provide assistance in changing PCPs, and provide assistance with member benefit issues, inquiries, problems, or complaints.

Element 2.9 – Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is met.

OFC maintains multiple procedures for resolving complaints and appeals, including Members Complaint Procedures, Standard Appeal Procedures, and the Expedited Appeal Procedures. These procedures address the fair hearing process for the State of Virginia Department of Medical Assistance Services (DMAS) and are communicated to members in the Member Guide.

Element 2.10 – Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is met.

The OFC Provider Directory is mailed to all members in their enrollment packets. The directory contains the names, addresses, and telephone numbers of PCPs, specialists, and hospitals. Practitioners who are no longer accepting new patients and those with age restrictions on the members they treat are identified. Information regarding providers who speak languages other than English is found on the Find a Doctor tool on www.optimahealth.com. This website can be accessed directly by members, or they may contact the Member Services Department for assistance.

Element 2.11 – Procedures for provider-enrollee communications.
This element is met.

The Member Rights and Responsibilities Policy states that members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. The policy further states that members have the right to discuss their medical records with

their physicians. Language reflecting this policy is documented in the Member Guide, which members receive upon enrollment.

Element 2.12 – Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is met.

The Member Rights and Responsibilities statement includes a provision that members have a right to obtain information on how providers are paid from the MCO. The statement further indicates that the MCO is prohibited from providing incentives to providers for issuing denials or limiting or discontinuing medical services. This statement is included in the Member Guide, which directs members to contact OFC's Member Services Department for more information regarding how they can obtain provider payment information.

Element 2.13 – Procedures to share information that enrollees are not liable for payment in case of MCO insolvency.
This element is met.

The Insolvency of MCO Policy states that language holding members harmless for payment in the case of MCO insolvency is included in the EOC section of the Member Guide. A review of the Member Guide confirmed the presence of this language.

Element 2.14 – Process for enrollment and disenrollment from MCO.
This element is met.

The File Uploads and Reports Policy describes the procedures used to enroll into and disenroll members from the MCO. These procedures are also described in the Member Guide and include how to enroll newborns.

ER3. Information and Language requirements (438.10).

Element 3.1 – MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) its particular service area.
This element is met.

OFC reported that no non-English-speaking group within its membership exceeds the 5% level at which DMAS requires an MCO to publish written member information in that language. The Interpreter and Translation Services Policy states that the OFC Member Orientation Guide and Member Education

video are available in Spanish. This policy further indicates that the AT&T Language Line is used to translate and explain member materials to members in other languages, as needed. The Member Guide directs members who need translation services to call the Member Services Department for assistance.

Element 3.2 – Enrollee information is written in prose that is readable and easily understood.
This element is met.

The Readability Policy states that Microsoft Word software is used to calculate the readability for all member materials, including all letters, member guides, and enrollment information. The Member Guide, Provider Directory, and sample member newsletters provided evidence that member materials are readable and easily understood.

Element 3.3 – State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).
This element is met.

The Readability Policy states that no program information document shall be used by OFC unless it achieves a Flesch total readability score of 40 or better (at or below a 12th grade educational level).

Element 3.4 – Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents are "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), [and] . . . notices advising LEP persons of the availability of free language assistance."
This element is met.

The Interpreter and Translation Services Policy states that the AT&T Language Line is used to translate and explain member materials to members in other languages, as needed. The Member Guide directs members who need translation services to call the Member Services Department for assistance and states that an interpreter is available to assist members in over 140 languages. Interpreter services are made available to members in their physicians' offices or at the MCO's offices.

Element 3.5 – MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is met.

The Member Guide indicates that oral translation of member materials and in-home member education sessions are available to visually impaired members by contacting the Member Services Department. A closed-captioned member education video is available for members who are hearing impaired.

Element 3.6 – MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.
This element is met.

The Interpreter and Translation Services Policy state that the MCO will cover interpreter services at no charge to the member. The policy states that interpreter services may be made available in a provider's or the MCO's offices through the use of the AT&T Language Line, interpreters accompanying members to the office, and office staff who speak a foreign language. The Member Guide directs members who need translation services to call the Member Services Department for assistance.

Element 3.7 – MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.
This element is met.

The Interpreter and Translation Services Policy states that the AT&T Language Line is used to provide interpretation services to members in other languages The Member Guide directs members who need translation services to call the Member Services Department for assistance, and states that an interpreter is available to assist members in over 140 languages.

Element 3.8 – MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is met.

The Interpreter and Translation Services Policy describes the various alternative formats for which member information is available. The Member Guide directs members to call the Member Services Department for assistance in accessing member materials in alternative formats.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26 (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 – MCO has a confidentiality agreement in place with providers who have access to PHI.
This element is met.

Confidentiality of protected health information (PHI) is addressed in OFC's provider contracts. The contracts state that clinical records of members containing identifiable information shall be regarded as

confidential and the provider is required to comply with all applicable Federal and State laws.

Element 4.2 – The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).
This element is met.

OFC has multiple policies that describe the MCO's safeguards for preventing the use and disclosure of PHI. These include the Privacy of PHI Policy, the Authorization to Release Member Information Policy, the Disclosure of Member PHI Policy, and Handling Protected Information Policy.

Element 4.3 – The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.
This element is met.

The PHI to DMAS Policy describes the MCO's procedures for making member PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).

Element 5.1 – MCO has policies and procedures in place that define emergency and post-stabilization situations, describe what to do in an emergency, supply a telephone number and instructions for obtaining advice on getting care in an emergency, and state that prior authorization is not needed.
This element is met.

The Emergency Care and Treatment Policy states that emergency care does not require preauthorization in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition

existed. The policy states that the care is reviewed post-service to ensure it was medically necessary. OFC covers emergency room visits actually authorized by the member's PCP or other authorized MCO representatives.

The Member Guide provides members with a definition of what constitutes an emergency and what to do in cases of an emergency, including calling their PCPs, 911, or the OFC After Hours Nurse Triage Program. The EOC also includes this information.

Element 5.2– MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is met.

The Member Guide provides information to members regarding the use of after-hours medical services, including calling their PCPs and the use of the After Hours Nurse Triage Program, which is available Monday through Friday after the MCO's normal business hours and 24 hours a day on weekends. The MCO maintains both local and toll-free telephone numbers for the After Hours Nurse Triage Program, and the numbers are also listed on members' ID cards.

Element 5.3 – MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is met.

The Member Guide provides members with a definition of what constitutes an emergency and what to do in cases of an emergency, including calling their PCPs, 911, or the OFC After Hours Nurse Triage Program. The EOC also includes this information.

Element 5.4 – MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation. (Medical HelpLine Access).
This element is met.

The Member Guide directs members to call Family Care Transportation at a toll-free number that is available 24 hours a day, 7 days a week, to arrange transportation to a medical care or mental health appointment. Emergency ambulance transportation is covered by OFC when ordered in advance by a PCP or from wherever an injury or symptoms occurred. The EOC also includes this information.

Element 5.5 – MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.

This element is met.

The Provider Directory, which members receive upon enrollment, identifies the OFC network hospitals that provide emergency and post-stabilization services.

ER6. Advanced Directives.

Element 6.1 – The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is met.

The Member Guide provides information to members regarding the Federal Patient Self-Determination Act and includes a Summary of Policies on Patient Rights and Advance Directives. The summary indicates that it is a member's right to accept or refuse medical or surgical treatment and to formulate advance directives.

Element 6.2– MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is met.

The Member Rights and Responsibilities statement is published in the Member Guide and includes the right of members to participate in the decision-making process with their doctors regarding their health care.

Element 6.3– Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is met.

The Member's Rights and Responsibilities Policy, which includes the MCO's Member Rights statement, is published in the Member Guide and includes the right of members to participate in decision making about their health care, to refuse treatment to the extent permitted by law, and be made aware of the potential medical consequences of such action.

Element 6.4 – MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is met.

The Family Planning Policy states OFC members may obtain confidential family planning and birth control services from any participating provider without a referral from their PCPs, and that the services are confidential. This information is communicated to members through the Member Guide.

Element 6.5 – MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is met.

The EOC in the Member Guide contains a provision that OFC provides coverage for second opinions, upon member request, for diagnosing an illness and/or confirming a treatment and pattern of care. The provision indicates that all of OFC's preauthorization and referral requirements apply regarding members' receipt of second opinions.

ER7. Rehabilitation Act, ADA.

Element 7.1 – MCO is in compliance with Federal and State laws regarding enrollee confidentiality.
This element is met.

The MCO's Notice of Insurance Information Practices and Financial Information Practices describes the procedures in place to ensure member privacy and confidentiality. Member confidentiality is also addressed in the Privacy of PHI Policy, the Authorization to Release Member Information Policy, the Disclosure of Member PHI Policy, and Handling Protected Information Policy.

Element 7.2 – MCO has provided the enrollee with a description of their confidentiality policies.
This element is met.

The MCO's Notice of Insurance Information Practices and Financial Information Practices is included in the Member Guide, which is distributed to all new members.

Element 7.3 – MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is met.

The Notice of Insurance Information Practices and Financial Information Practices published in the Member Guide provides members with information regarding how to obtain a copies of their medical records and how to request records from the MCO.

QA1. 438.206 Availability of Services.

Element 1.1 – – MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:

- Network Provider Composition.
- Provider Enrollment into Medicaid.
- Network Provider Licensing and Certification Standards.
- Enrollee to PCP ratios.
- Specialist Services.
- Enrollee to Dentist Ratios.
- Inpatient Hospital Access.
- Policy of Nondiscrimination.
- Twenty-four hour coverage.
- Travel Time and Distance.
- Appointment Standards.
- Emergency Services Coverage – provider contracts.
- Monitoring/Corrective Action.

This element is met.

The Network Accessibility Analysis Policy defines the access and availability standards established by OFC. The policy outlines the standards for urban, suburban, and rural areas and the ratio of PCPs and specialists needed for each. The Member Guide includes the appointment standards established by the MCO for emergency, urgent, illness or injury, routine, and preventive care.

Element 1.2 – MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is met.

The Member Guide states members with disabilities, chronic illnesses, or special concerns may contact OFC's Member Services Department to have a specialists assigned as their PCPs.

QA2. 438.206 Availability of Services (b)(2).

Element 2.1 – MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is met.

The Family Planning Policy states that OFC female members may obtain annual GYN exams as well as confidential family planning and birth control services from any participating provider without a referral from their PCP. This information is communicated to members through the Member Guide.

QA3. 438.206 Availability of Services (b)(3).

Element 3.1 – MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

The Evidence of Coverage (EOC) located in the Member Guide contains a provision that OFC provides coverage for second opinions upon member request for diagnosing an illness and/or confirming a treatment and pattern of care. The provision indicates that all of OFC's preauthorization and referral requirements apply regarding a member's receipt of second opinions.

QA4. 438.206 Availability of Services (b)(4).

Element 4.1 – MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is met.

The Out of Area/Out of Network Services Policy describes the process by which members may obtain out-of-area and out-of-network services. The policy states that all out-of-area and out-of-network care must be reviewed by OFC's Case Management Department prior to medical necessity authorization and that services that are not available from an appropriately trained in-network provider will be reviewed by Medical Care Management for authorization to an appropriate provider. The procedures for obtaining out-of-area and out-of-network services are communicated to members in the Member Guide.

QA5. 438.206(c)(2) Cultural considerations.

Element 5.1 – The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is met.

The Cultural Diversity Policy states that the MCO promotes the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural

and ethnic backgrounds. The Interpreter and Translation Services Policy outlines OFC's procedures for assisting members who need language translation and interpreter services and those who are visually and hearing impaired.

QA6. 438.208 Coordination and Continuity of Care.

Element 6.1 – MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.
This element is met.

The MCO maintains various policies and procedures that address coordination and continuity of care. The policies describe the provision of case management services for members with high-risk and high-cost conditions, members who are hospitalized, members receiving behavioral health services, and those whose benefits change.

QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs.

Element 7.1 – The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is met.

The Process for Completing and Processing the Member Orientation Form Policy and the Process to Complete and Process Clinical Intake Screen Policy describes the procedures by which the MCO assesses members to determine whether they have special needs upon enrollment. These procedures are used by the MCO to collect data in an effort to identify possible early interventions for disease management and prenatal care. The data are collected within 90 days of a member's enrollment.

QA8. 438.208(c)(4) Direct Access to Specialists.

Element 8.1 – The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is met.

The Specialist Acting as Primary Care Policy states that special needs members will have an assigned PCP but may be authorized to see a specialist for one year with unlimited rights and privileges, as appropriate. The specialist may also refer and provide other primary care services to members.

The Member Guide states that members with disabilities, chronic illnesses, or special concerns have the option of having a specialist assigned as their PCP. Members must contact OFC's Member Services Department to initiate this assignment.

Element 8.2 – Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.
This element is met.

The Services Requiring Authorization and Timeframes for Decisions Policy outlines the specialty care services that require preauthorization. This policy and the Pre-service Authorization/Hospital Inpatient Admissions Policy and the Pre-Service Authorization/Outpatient Surgical Procedures Policy describe the procedures required for PCPs to refer members to specialty care.

Element 8.3 – The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is met.

The Case Management Process Policy describes how case management (CM) plans are created and provide coordination of services, involving both physicians and patients. The case manager is responsible for coordinating discharge planning and outpatient needs for the member while updating the plan. Members and providers have input on the plan and are contacted whenever there are changes to the CM plan. Members always have the option to terminate services.

The Specialist Acting as Primary Care Policy details how specialists may manage certain members. "The member will have a PCP but the authorization to the specialist may be for one year without restrictions allowing the specialist to refer and provide other primary care services." This includes (as noted above) working with the case managers to facilitate a care plan that is timely and involves the enrollee.

QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans.

Element 9.1 – The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is met.

The Continuity and Coordination of Care Policy describes the process for OFC to provide the exchange of information between medical and behavioral health providers in an effective and timely manner, to coordinate care.

The Case Management Process Policy describes how CM plans are created and provide coordination of services, involving both physicians and patients.

QA10. 438.208(e) Primary Care and Coordination Program.

Element 10.1 – MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is met.

The Case Management Process Policy describes how through CM plan development duplication of services is eliminated by appropriate care coordination.

Element 10.2 – Coordination of care across settings or transitions in care (NCQA QI-9). Continuity and coordination between medical and behavioral health care for co-existing conditions.
This element is met.

The Continuity and Coordination of Care Policy describes the process for communication between medical and behavioral health providers, to coordinate care. It is an expectation of OFC that behavioral health practitioners will obtain member consent to share information to the member's PCP when the member presents for treatment.

Element 10.3 – MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is met.

The Confidentiality of Member Data and Member Medical Records Policy details issues of confidentiality of enrollee information.

The Statement of Responsibility & Confidentiality also reinforces the need for protection of enrollee privacy. This statement must be signed by employees who have access to Sentara Healthcare information, files, data, or computer applications.

QA11. 438.210 (b) Coverage and Authorization of Services – Processing of requests.

Element 11.1 – The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions contains the requirements for processing requests for initial and continuing authorizations for services.

Element 11.2 – MCO has a policy and procedure in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services and basic prenatal care.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions waives the prior-authorization requirement for family planning, basic prenatal care, and preventive or emergency services.

Element 11.3 – The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application,
This element is met.

The policy and procedure Inter-rater Review Medical Care Management (MCM) Staff contains a description of the procedures for evaluating the consistent application of review criteria by MCM staff.

Element 11.4 – The MCO has a policy and procedure in place for staff to consult with requesting providers when appropriate.
This element is met.

The policy and procedure Appeal Process for Adverse Decisions permits the physician advisor to contact the attending physician to discuss the case in question by phone. If appropriate, copies of progress notes, consultations, and the like will be transmitted by facsimile machine. Every effort is to be made to resolve the issue.

Element 11.5 – If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is met.

The delegation agreements for Cole Managed Vision and Doral Dental include a description of the mechanism by which authorization activity is reported to OFC.

Element 11.6 – Subcontractor's UM plan is submitted annually and upon revision.
This element is met.

The policy and procedure Subcontractor Monitoring requires that all subcontractor quality improvement and utilization management plans be submitted to OFC each year for review.

Element 11.7 – The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is met.

The policy and procedure Adverse Decisions/Reconsideration (Pre-service/Concurrent/Post-service Review) requires that if the attending physician requests reconsideration of the situation by another physician the MCO may coordinate the review of the specific case with a physician advisor of the appropriate specialty before issuing an adverse decision.

Element 11.8 – MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions describes the authorization time frames as outlined in the MCO Medallion II agreement.

Element 11.9 – MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions prohibits care management staff involved in the decision making from being provided incentives for approving, denying, limiting, or discontinuing services or authorizations for OFC members.

QA12. 438.210 (c) Coverage and authorization of services – Notice of adverse action.

Element 12.1 – MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions requires that, after all pertinent information has been reviewed by the Medical Director, the decision will be phoned to the requesting provider within three working days and written notification will be sent to provider and member of any adverse decision.

QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.

Element 13.1 – MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee request extension or MCO justifies a need for additional information.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions requires that, after all pertinent information has been reviewed, an authorization notice must be provided within 14 days. The Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedure permit an additional 14 days upon written notification to the member or requesting provider, if the extension is shown to be to the advantage of the member.

QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions.

Element 14.1 – The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for Decisions requires that urgent or expedited requests for services must be resolved within 24 to 72 hours of the receipt.

Element 14.2 – The MCO has a policy and procedure relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is met.

The policy and procedure Services Requiring Authorization and Timeframes for provides that where a delay will not put the member at permanent risk, the MCO may extend the notification deadline by 14 days in order to seek information needed to assist in making the determination.

QA15. 438.214 (b) Provider selection –Credentialing and recredentialing requirements.

Element 15.1 – The MCO has written policies and procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is met.

The Credentialing and Recredentialing Policy describes in detail the process for selection and retention of providers. Practitioners are recredentialed no less frequently than every 36 months. To ensure that practitioners have no significant quality issues outside the health plan, monitoring organizations are queried.

Element 15.2 – MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.
This element is met.

The Quality Improvement Review for Recredentialing Practitioners Policy (October 2004) discusses how review of quality information/data will be used to for recredentialing practitioners. The data are collected during the time between credentialing and recredentialing. The data document:

- Member complaints.
- Inpatient/outpatient occurrences.
- Medical record reviews.
- Peer review.
- Quality indicators.

The Credentialing Department runs quarterly reports regarding complaints and reviews the number of complaints for all practitioners. Per the policy, "Areas of concern will be presented at the time of incident and/or during the recredentialing process to the Credentials Committee. The Committee will determine if any actions will be taken."

Element 15.3 – MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.

This element is met.

The Credentialing and Recredentialing Policy describes how the National Practitioner Data Bank (NPDB) and the State Medical Board are notified regarding any quality issues, limitation in participation, or cancellation of a contract, as defined by State and Federal regulations.

The Right to Fair Hearing and Appellate Review Policy describes how the provider is made aware of a potential "Adverse Action" decision, and of the appeal and hearing process. Time frames for actions and activities are clearly spelled out in this policy. The provider is notified in writing of the outcome of the hearing.

QA16. 438.214 (c) Provider selection – Nondiscrimination.

Element 16.1 – MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is unmet.

Although the Network Composition Policy has a section discussing discrimination against the physician based on licensure and social, economic, racial or other demographics, the policy in place in 2005 did not specifically address discrimination against physicians on the basis of the populations served or costly patient populations. The policy was updated and revised January 1, 2006, and now meets the requirements of the element.

To receive a determination of met in the next review, OFC must ensure that the Network Composition Policy, as revised in January 2006, continues to include the policies and procedures that ensure the MCO will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

QA17. 438.12 (a,b) Provider discrimination prohibited.

Element 17.1 – For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is met.

Per the New Practitioner Credentialing Process (Active Approval), "when a provider is denied . . a letter will be signed by the SHP Medical Director notifying the issues for denial . . . [and] the provider may enter an appeal in person and /or in writing."

QA18. 438.214 (d) Provider Selection – Excluded Providers.

Element 18.1 – MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is met.

Compliance with this element is found within the provider contract, which includes information on termination of providers and ineligible providers.

QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO.

Element 19.1 – MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is met.

According to DMAS requirements, the MCO is precluded from disenrolling a member. A request for member disenrollment is referred to DMAS. Disenrollment procedures are described in the Member Guide.

QA20. 438.56 (c) Provider Enrollment and Disenrollment – Requested by Enrollee.

Element 20.1 – MCO has policies and procedures in place for enrollees to request disenrollment.
This element is met.

The OFC Member Guide describes what the member needs to do to disenroll. The section, "What if I want to switch to a different Plan?" describes how the member can contact the State to initiate a transfer. This transfer out of the MCO does not directly involve the health plan.

Element 20.2 – MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is met.

The policy and procedure PCP/Specialist/Provider Site Termination Notification to Members discusses how members are notified of a termination of their PCP. Information, including a draft letter, is found in this policy.

QA21. 438.228 Grievance systems.

Element 21.1 – MCO has a process for tracking requests for covered services that were denied.
This element is met.

The policy and procedure Standard Appeals Procedures requires the OFC Appeals Coordinator to prepare a summary report of OFC appeals and present it to the OFC Project Coordinator by the fifteenth day of each month for submission to DMAS. OFC and FAMIS member appeals will be compiled and reported to DMAS on a monthly basis.

Element 21.2 – MCO has process for fair hearing notification.
This element is met.

The policy and procedure Standard Appeals Procedures requires that OFC members be notified of their right to appeal directly to DMAS before, during, or after the MCO's appeal process. DMAS will conduct an evidentiary hearing that will not be based upon any appealed decision by the MCO. The Appeals Coordinator will prepare and submit an appeal summary to DMAS and to the member at least 10 days prior to the date of the State Fair Hearing.

Element 21.3 – MCO has process for provider notification.
This element is met.

The policy and procedure Adverse Decisions/Reconsideration (Pre-service/Concurrent/Post-service Review) requires that written notification of an adverse decision must be made to the attending physician and facility as appropriate. This notification will be sent to the attending physician, provider, and facility within 24 hours of the issuance of an adverse decision.

Element 21.4 – MCO has process for enrollee notification and adheres to state timeframes.
This element is met.

The policy and procedure Adverse Decisions/Reconsideration (Pre-service/Concurrent/Post-service Review) requires that written notification of an adverse decision must be sent by mail or issued in person to the member within 24 hours or one working day of the decision being made.

QA22. 438.230 Subcontractual relationships and delegation.

Element 22.1 – MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is met.

Per the Credentialing and Recredentialing Plan, Section VII – Delegation Audit and the Procedures for Delegation the Network, the Management Department will contact the Credentialing Department to conduct a credentialing site visit of the potential delegate. Policies and procedures are reviewed prior to an on-site review. The Credentialing Manager will contact the site and review files, based on the NCQA and SHP standards. Recommendations are made after the review if specific actions must be taken before delegation can proceed. Annual site visits are conducted.

Element 22.2 – MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is met.

Contracts for delegation have been reviewed, including those with Medical Transportation Management (MTM), Doral, and Cole (2005), and were found to demonstrate the activities and report responsibilities of a delegated entity.

Element 22.3 – MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is met.

Processes were found in the vendor contracts that would revoke delegation or result in imposing of sanctions if performance was inadequate.

Element 22.4 – MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is met.

The process for annual review includes review of reports provided to OFC as required in the delegate's contract. While these actions are occurring through regular oversight, there is no policy that describes how this review occurs. It is recommended that a policy be written to codify this oversight process.

QA23. 438.236 (a, b) Practice guidelines.

Element 23.1 – The MCO has adopted practice guidelines that meet current NCQA standards and the following:
This element is met.

The Development of Clinical/Preventive Guidelines Policy elucidates the process for the development/implementation of outpatient clinical and preventive practice guidelines for PCPs. Guidelines are generated based on:

- Review of demographic and epidemiologic information related to populations that are high volume, high cost, and/or problem prone.
- Areas that have the potential for overutilization or underutilization, including new technology.
- Newly issued or updated national clinical or preventive guideline standards based on current scientific knowledge.

The Physician Advisory Council (PAC) and/or the Disease Management Teams identify appropriate guideline authors who review the current literature for relevant new information, that is, the latest scientific data, national standards, and expert opinion. Input is obtained by consulting Subject Content Experts are "Specialty Advisors, other community specialty physicians, and Disease Management Physician Advisors."

The Guidelines are initially reviewed by members of the PAC for initial critique and recommendations. Final approval comes from the PAC.

The Clinical Guidelines/Referral Guidelines Manual is distributed annually to all practitioners. New providers receive the Guidelines during the Provider Relations orientation. Guidelines are reviewed/revised at least biennially.

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is met.

As noted above, guideline authors search the current scientific literature for information, review the latest national standards, and seek expert opinion. Input is obtained by consulting Subject Content Experts and other physicians.

b) Consider the needs of the enrollees.
This component is met.

As noted above, the Guidelines are based on review of demographic and epidemiologic information related to population. Guideline authors search the current scientific literature for information, review national standards, and seek expert opinion.

c) Are adopted in consultation with contracting health care professionals, and
This component is met.

As noted above, input is obtained by consulting Subject Content Experts, specialty advisors and other community specialty physicians, and Disease Management physician advisors. These physcians include network and contracted providers.

d) Are reviewed and updated periodically, as appropriate.
This component is met.

As noted above, the Guidelines are reviewed and if necessary revised at least biennially. This was evidenced in documented revision or review dates noted on the guidelines.

QA24. 438.236 (c) Dissemination of Practice Guidelines.

Element 24.1 – The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is met.

The Member Rights and Responsibilities Policy state that the enrollees may have a copy of the Guidelines upon request.

The policy Development of Clinical/Preventive Guidelines states that the Clinical Guidelines/Referral Guidelines Manual is distributed annually to all practitioners.

QA25. 438.236 (d) Application of Practice Guidelines.

Element 25.1 – MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is met.

The Inter-rater Review MCM Staff Policy (June 2005) explains how a monthly audit is conducted to assure consistency with guidelines and policies. It demonstrates compliance with processes utilizing the Medical Care Management Policy and medical criteria. The areas audited include:

- Adherence to medical care policies.
- Policy compliance.
- Coding appropriateness.
- Policies requiring Medical Director authorization.

QA26. 438.240 Quality assessment and performance improvement program.

Element 26.1 – MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is met.

The 2005 QI Program demonstrates the process by which quality assessment and performance is occurring. The Quality Improvement Program Evaluation 2004 demonstrates the effectiveness of activities that occurred as the result of the prior year's QI Program.

Element 26.2 – MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is met.

The NCQA Quality Improvement Activity Form was reviewed concerning activities in the area of improving care for asthma. This form detailed the asthma project, including, but not limited to, the rationale for the project, data sources, indicators descriptions, interventions, and measurement data.

Element 26.3 – The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is met.

Review of the content of the QI Program Description for 2005 and Quality Improvement Program Evaluation 2004 demonstrate evidence that the MCO monitors itself and initiates corrective action policies as indicated.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 – MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is met.

The QI Program annual review discusses under and over utilization issues, for example, in the area of medication use for chronic illness such as asthma, diabetes, and cardiac diseases. The Guidelines also address issues of under and over utilization concerning patient care and use of technology.

QA28. 438.240 (b) (3) Basic elements of QAPI program – Care furnished to enrollees with special health needs.

Element 28.1 – MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is met.

Multiple documents were reviewed to determine adequacy of the MCO to assess the quality of services provided to special needs individuals. The Case Management Process Policy describes how Case Management coordinates services and how Case Managers are involved with continuity of care and education on the disease process and with services for special needs individuals. The MCO's Quality Improvement Program 2005 also reflects activities consistent with this element.

QA29. 438.242 Health/Management Information systems.

Element 29.1 – The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is met.

Review of the information provided reveals that the MCO has a functioning information system that is able to:

- Identify populations for studies and case management.
- Provide information for CAHPS and HEDIS samples.
- Ensure reports are regularly sent to DMAS.

Element 29.2 – The MCO information system is capable of:

a) Accepting and processing enrollment reports.

b) Reconciling reports with MCO enrollment/eligibility files.
c) Accepting and processing provider claims and encounter data.
d) Tracking provider network composition, access to services, grievances and appeals.
e) Performing QI activities.

This element is met.

The policy from the Account Service Policy and Procedure Manual, 820. File Upload & Reports, describes how monthly DMAS provides financial information to the MCO.

The policy from the Account Service Policy and Procedure Manual, Amounts Paid by DMAS, Report October 1999, discusses how information on members is exchanged with DMAS.

The policy from the Account Service Policy and Procedure Manual, Baby Delivery/Infant Re-certify Reports April 1998, describes how newborns are identified and the information is sent to DMAS. These newborns must be identified weekly to ensure coverage. The procedure is able to identify infants approaching their three-month cutoff dates who still do not have Medicaid numbers.

Element 29.3 – Furnishing DMAS with timely, accurate and complete clinical and administrative information.

This element is met.

The policy from the Account Service Policy and Procedure Manual, Policy Section: DMAS Membership with PCP Information File August 2003 demonstrates the ability of the MCO to provide DMAS with a monthly file containing OFC's entire membership and the PCP's assigned to each of its members.

Element 29.4 – MCO ensures that data submitted by providers is accurate by:

a) Verifying the accuracy and timeliness of reported data.
b) Screening the data for completeness, logic, and consistency.
c) Collecting service information in standard formats for DMAS.
d) Assigning unique identifiers to providers and requiring that identifiers are used when providers submit data to MCO.

This element is met.

The Claims – Electronic Data Interchange (EDI) Policy discusses how the MCO has contracted with a number of clearinghouses are to be able to transfer data and convert to appropriate formats accurately. The software reformats information for interchange between vendors, providers, and the MCO.

The DMAS Encounter File Transmissions P-policy discusses the ability to transfer information between DMAS and the MCO, including encounter information.

Element 29.5 – MCO uses encryption processes to send PHI over the internet.
This element is met.

The Secure Transmission of Clinical Data Over the Internet discusses how the Internet is used to send encrypted information. Specific encryption methods were noted in the policy.

GS1. 438.402 (a, b) Grievance System.

Element 1.1 – MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures contain a description of the procedures for submitting and management of a complaint or an appeal.

Element 1.2 – The definitions for grievances and appeals are consistent with those established by the State in July 2003.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures define grievances and appeals as follows:

Grievance – An expression of dissatisfaction about any matter other than an "action." This definition is also used to refer to the overall system that includes grievance/complaints and appeals handled at the MCO level and access to the State fair hearing process. Examples include: quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights, etc.

Appeal – A request for review of an action.

These definitions are consistent with those established by the State of Virginia Department of Medical Assistance Services (DMAS).

Element 1.3 – Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures require that all OFC grievances and appeals must be tracked and reported separately from all other Optima lines of business.

Element 1.4 – Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures require that all member complaints must be resolved within 30 days of receipt of the complaint. Appeals must be resolved within the standard time frame of thirty days or the expedited period of three days, depending on the nature of the situation or type of care requested.

Element 1.5 – Policies and Procedures describe the documentation process and actions taken.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures contain a description of the process for accepting, reviewing, resolving and reporting of a grievance or appeal.

Element 1.6 – Policies and procedures describe the aggregation and analysis of the data and use in QI.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures require that all complaints as well as appeals be collected in respective databases for trending and analysis.

Element 1.7 – The procedures and any changes to the policies and procedures must be submitted to the DMAS annually.
This element is met.

There was documentation provided that the Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures are submitted to DMAS each year for review.

Element 1.8 – MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is met.

The delegation agreements and policies and procedures for grievances and appeals as well as the OFC Provider Manual include a description of the OFC grievance and appeals practices.

GS2. 438.402 (3) Filing Requirements – Procedures.

Element 2.1 – The MCO has grievance and appeal forms and provides enrollees with written procedures to enrollees who wish to register written grievances or appeals.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures as well as the OFC Member Guide contain a description of the process for registering a complaint or appeal and instructions on how to obtain assistance with filing a written appeal.

Element 2.2 – The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is met.

The OFC Member Guide includes instructions on how to obtain assistance with filing an appeal in writing, including the use of translation services and the TTY.

GS3. 438.404 Notice of Action.

Element 3.1 – Notice of action is written according to language and format requirements set forth in GS. 438.10 Information Requirements.
This element is met.

The notices of action that were reviewed are written in a manner that is easily understood. The appeal instructions included in the notice of action contain the telephone number and address for contacting OFC as well as submitting information to the MCO. The instructions indicate that assistance with filing an appeal or grievance is available upon request.

GS4. 438.404 (b) Content of Notice of Action.

Content of the notice of action explains all of the following:

Element 4.1 – The action taken and reasons for the action.
This element is met.

The notices of action that were reviewed contain a description of the action taken and the reason for that action.

Element 4.2 – The enrollee's right to file an appeal with MCO.
This element is met.

The notices of action that were reviewed contain a description of the enrollee's right to file an appeal as well as the procedure and contact information for filing an appeal.

Element 4.3 – The enrollee's right to request a State fair hearing.
This element is met.

The notices of action that were reviewed contain the address to submit an appeal to the DMAS appeals department. The notices of action that were reviewed contain the address to submit an appeal to the DMAS appeals department. The member appeals packet that is provided to members by OFC includes a description of the enrollee's right to a State fair hearing.

Element 4.4 – The procedures for exercising appeal rights.
This element is met.

The notices of action that were reviewed include a description of the procedures for exercising appeal rights.

Element 4.5 – The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is met.

The notices of action that were reviewed indicate that an expedited appeal may be requested if the request for services was an urgent request or loss of life or permanent injury could result from non-payment.

Element 4.6 – The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is met.

The OFC member appeal packet includes a requirement that an enrollee may request the continuation of benefits while an appeal is pending under the following conditions:

- The member or the provider, on behalf of the member, files the appeal within 10 days of the MCO's mail date of the notice of adverse action or prior to the effective date of the MCO's notice of adverse action; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
- The services were ordered by an authorized provider; and
- The original period covered by the initial authorization has not expired; and
- The member requests extension of benefits.

Additionally, the member will be notified that if the final resolution of the appeal is adverse to the member, the MCO may pursue recovery of the cost of services furnished to the member while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above.

GS5. 438.416 Record Keeping and Reporting Requirements.

Element 5.1 – The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures require that all appeals and grievance files be maintained for seven years following the filing of the appeal or complaint. Documentation provided indicates that this process is in place and functioning.

GS6. 438.406 Handling of Grievances and Appeals – Special Requirements for Appeals.

Element 6.1 – MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.
This element is met.

The policy and procedure Standard Appeals Procedures requires that if the adverse action under appeal relates in whole or in part to a medical judgment, including determinations regarding whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, a peer of the treating health care provider will review the decision.

Does this policy state that "individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making?" This part of the question does not appear to be answered.

Element 6.2 – MCO provides that oral inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider requests expedited resolution.
This element is met.

The policy and procedure Standard Appeals Procedures requires that all verbal requests for appeals will be documented into the customer service data system and the content of the appeal will be sent to the member along with an appeal packet and form. The member must confirm the content of the appeal in writing. Those appeals that are not confirmed will be closed. Written acknowledgment of expedited appeals is not required.

Element 6.3 – MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.
This element is met.

The policy and procedure Standard Appeals Procedures requires that OFC provide the member with a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. Additionally, the member and his or her representative will be given the opportunity, before and during the appeals process, to examine the member's case file, including medical records and other documents and records considered during the appeals process.

Element 6.4 – MCO informs enrollee of limited time available for cases of expedited resolution.
This element is met.

The appeals packet includes a requirement that all expedited appeals must be resolved within 72 hours of the request for an expedited appeal.

Element 6.5 – MCO permits enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is met.

The appeals packet includes instructions for access to the enrollee case file by an enrollee or designated representative. The packet also includes instructions and appropriate forms for designating a family member or representative to act for a member during the appeals process.

Element 6.6 – MCO continues benefits while appeal or State fair hearing is pending.
This element is met.

The OFC member appeal packet includes a requirement that an enrollee may request the continuation of benefits while an appeal or State fair hearing is pending. The packet contains a statement that the MCO may pursue recovery of the cost of care provided in the event that the appeal determination for those continued services is not in favor of the enrollee.

GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution.

Element 7.1 – MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires – not exceeding 30 days from initial date of receipt of the appeal.
This element is met.

The policy and procedure Standard Appeals Procedures requires OFC to complete its review of an adverse action and give the OFC member written notification of the outcome within 30 days from the date of the initial receipt of the appeal request and after all information has been received.

Element 7.2 – In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is met.

The policy and procedure Standard Appeals Procedures states that OFC will provide written notice to the member with the reason for the delay for any appeal decisions not rendered within 30 days where the member has not requested an extension. FAMIS appeals will be decided and written notification of the outcome will be sent to the member within 14 days of the initial receipt of the appeal request and after all information has been received.

GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals.

Element 8.1 – MCO has an expedited appeal process.
This element is met.

The policies and procedures Optima Family Care and FAMIS Member Complaints Procedure and Standard Appeals Procedures contain a description of the expedited appeals process.

Element 8.2 – The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is met.

The policy and procedure Standard Appeals Procedures requires that the expedited appeal decision must be rendered within three business days of the receipt of the appeal for OFC members. Decisions will be made within two business days of the recipient's appeal for FAMIS expedited appeals.

Element 8.3 – MCO has a process for extension, and for notifying enrollee of reason for delay.
This element is met.

The policy and procedure Standard Appeals Procedures states that OFC will provide written notice to the member with the reason for the delay if an appeal decision is not rendered within 30 days where the member has not requested an extension. FAMIS appeals will be decided and written notification of the outcome will be sent to the member within 14 days of the initial receipt of the appeal request and after all information has been received.

Element 8.4 – MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow up within two calendar days with a written notice of action.
This element is met.

The policy and procedure Expedited Appeals requires that OFC will make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow up within two calendar days with written notification of the MCO's final decision.

GS9. 438.408 (b -d) Resolution and Notification.

Element 9.1 – MCO decisions to expedited appeals are in writing and include decision and date of decision.
This element is met.

The policy and procedure Expedited Appeals requires that written notification to the member of the appeal result include and is not limited the following information:

- The MCO's decision;
- The date of decision;

- The policies or procedures which provide the basis for the decision;
- The right to request a State fair hearing, the time frame to file, and how to do so;
- The right to request to receive benefits while the hearing is pending and how to make the request when appropriate, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the MCO.

Element 9.2 – For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is met.

The policy and procedure Expedited Appeals contains a description of the right to request a State fair hearing, the time frame to file, and how to do so. The right to request to receive benefits while the hearing is pending and how to make the request when appropriate are also explained, with the proviso that the member may be held liable for the cost of those services if the hearing decision upholds the MCOs final decision.

Element 9.3 – MCO gives enrollee oral notice of denial and follows up within two calendar days with written notice.
This element is met.

The policy and procedure Expedited Appeals requires that OFC will make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow up within two calendar days with written notification of the MCO's final decision.

GS10. 438.408 (c) Requirements for State Fair Hearings.

Element 10.1 – MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is met.

The policy and procedure Standard Appeals Procedures contains the requirement that the member or the provider, on behalf of the member, file the appeal within 30 days of the MCO's mail date of the notice of adverse action or prior to the effective date of the MCO's notice of adverse action. The notice also includes the requirements for a State fair hearing.

Element 10.2 – MCO provides state with a summary describing basis for denial and for appeal.
This element is met.

The policy and procedure Standard Appeals Procedures requires the OFC Appeals Coordinator to prepare a summary report of OFC appeals and present it to the OFC Project Coordinator by the 15th day of each month for submission to DMAS. OFC and FAMIS member appeals are compiled and reported to DMAS on a monthly basis.

Element 10.3 – MCO faxes appeal summaries to state in expedited appeal cases.
This element is met.

The policy and procedure Standard Appeals Procedures requires that if a member appeals through the DMAS Appeals Division, the Appeals Coordinator will prepare a summary and submit it to DMAS by facsimile and mail to the member as expeditiously as the member's health condition requires but not later than four business hours after DMAS informs the MCO of the expedited appeal.

GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions.

Element 11.1 – The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or a State Fair Hearing reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is met.

The policy and procedure Standard Appeals Procedures requires that if the Medical Director (Medical Appeals) or the Appeals Manager (Benefit Appeals) determines there is sufficient evidence to reverse and approve the adverse action, the Appeals Coordinator will notify the member of the approval. The I-Max and Appeal databases will be updated and the appropriate action will be taken by the Appeals Coordinator.

Element 11.2– MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is met.

The policy and procedure Standard Appeals Procedures requires that the decision made by DMAS shall be final and will not be subject to appeal by the MCO. If the member is not in agreement with the resolution of DMAS, the member may appeal such decision to the Circuit Court.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1	Member Rights and Responsibilities Policy	07/2005
	OFC Member Guide	07/2005
	Out of Area/Out of Network Services Policy	08/2005
	PCP/Specialist/Provider Site Termination Notification to Members Policy	07/2004
	Member Complaint Procedures	07/2005
	Member Appeals Procedures	03/ 2005
	Expedited Appeals Procedures	03/2005
	Interpreter and Translation Services Policy	12/2005
	Insolvency of MCO Policy	07/2005
	File Uploads and Reports	07/2003
ER 2	Services Requiring Authorization and Timeframes for Decisions Policy	06/2005
	Family Planning Policy	01/2006
	OFC Provider Directory	08/2005
ER 3	OFC Orientation Guide	12/2005
	Readability Policy	02/2004
ER 4	Privacy of PHI Policy	04/13/2004
	Authorization to Release Member Information Policy	01/04/2006
	Disclosure of Member PHI Policy	06/14/2004
	Handling Protected Information Policy	02/03/2005
	PHI to DMAS Policy	03/2004
ER 5	Emergency Care and Treatment Policy	10/2005
QA 1	Network Accessibility Analysis Policy	09/2005
	OFC Member Guide	07/2005
QA 2	Family Planning Policy	01/2006
QA 5	Cultural Diversity Policy	05/2005
QA 7	Process for Completing and Processing the Member Orientation Form Policy	08/2002
	Process to Complete and Process Clinical Intake Screen Policy	08/2002
QA 8	Specialist Acting as Primary Care Policy	08/2003
	Case Management Process Policy	7/2005
	Specialist Acting as Primary Care Policy	8/2003
QA 9	Continuity and Coordination of Care Policy	1/19/ 2004
	Case Management Process Policy	7/2005
QA 10	Case Management Process Policy	7/2005
	Continuity and Coordination of Care Policy	1/19/2004
	Confidentiality of Member Data and Member Medical Records Policy	6/13/2005
	Statement of Responsibility & Confidentiality	(undated)
QA 15	Credentialing and Recredentialing Policy	11/2004
	Quality Improvement Review for Recredentialing Practitioners Policy	10/ 2004
	Credentialing and Recredentialing Policy	11/2004
	Right to Fair Hearing and Appellate Review Policy,	10 2004
QA 16	Network Composition Policy	1/1/2006
QA 17	New Practitioner Credentialing Process (Active Approval)	5/2005
QA 20	OFC Member Guide	(undated)
	PCP/Specialist/Provider Site Termination Notification to Members	July 2004
QA 22	Credentialing and Recredentialing Section VII – Delegation Audit	11/2004
	Procedures for Delegation	10/ 2004
	Contacts for delegation have been reviewed including MTM, Doral, and Cole Contracts	2005
QA 23	Development of Clinical/Preventive Guidelines Policy	7/2005
QA 24	Member Rights and Responsibilities Policy	7/2005
	Development of Clinical/Preventive Guidelines	7/2005
QA 25	Inter-rater Review MCM Staff Policy	7/2005

Summary of Documents Reviewed		
Element	**Document**	**Date**
QA 26	NCQA Quality Improvement Activity Form	2005
	2005 Quality Improvement Program	2005
	Quality Improvement Program Evaluation	2004
QA 27	Quality Improvement Program Evaluation	2004
QA 28	Case Management Process Policy July	2005
QA 29	Policy from the Account Service Policy and Procedure Manual 820 File Upload & Reports	7/2003
	Policy from the Account Service Policy and Procedure Manual, Amounts Paid By DMAS Report	10/1999
	Policy from the Account Service Policy and Procedure Manual, Baby Delivery/Infant Re-certify Reports	4/1998
	Policy from the Account Service Policy and Procedure Policy Section: DMAS Membership with PCP Information File	8/2003
	The Claims - Electronic Data Interchange (EDI) Policy	3/16/2005
	DMAS Encounter File Transmissions	6/2005
	The Secure Transmission of Clinical Data Over the Internet	1/2001
GS 1-11	Optima Family Care and FAMIS Member Complaints Procedure	7/ 2005
	Standard Appeals Procedures	3/2005
	Expedited Appeal	3/2005
	Services Requiring Authorization and Timeframes for Decisions	6/2005
	Inter-rater Review MCM Staff	6/2005
	Appeal Process for Adverse Decisions	7/2005
	Subcontractor Monitoring	12/2005
	Adverse Decisions/Reconsideration (Pre-service/Concurrent/Post-service Review)	9/2005

Section II - Performance Improvement Projects

Introduction

As part of the annual External Quality Review (EQR), Delmarva conducted a review of Performance Improvement Projects (PIPs) submitted by each managed care organization (MCO) contracting with the Department of Medical Assistance Services (DMAS). According to its contract with DMAS, each MCO is required to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. According to the contract, the PIPs must include the measurement of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. CMS' *Validation of PIPs* assists EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

For the current review period, calendar year (CY) 2005, the PIP validation protocols and tools established in 2003 were used. Reviewers evaluated each project submitted using the CMS validation tools. This included assessing each project across ten steps. These ten steps include:
Step 1: Review the Selected Study Topics,
Step 2: Review the Study Questions,
Step 3: Review the Selected Study Indicator(s),
Step 4: Review the Identified Study Population,
Step 5: Review Sampling Methods,
Step 6: Review the MCO's Data Collection Procedures,
Step 7: Assess the MCO's Improvement Strategies,
Step 8: Review Data Analysis and Interpretation of Study Results,
Step 9: Assess the Likelihood that Reported Improvement is Real Improvement, and
Step 10: Assess Whether the MCO has Sustained its Documented Improvement.

As Delmarva staff conducted the review, each component within a standard (step) was rated as "yes," "no," or "N/A" (not applicable). Components were then rolled up to create a determination of "met", "partially met", "unmet" or "not applicable" for each of the ten standards. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Performance Improvement Project Validation Review

Rating	Rating Methodology
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Results

This section presents an overview of the findings of the Validation Review conducted for each PIP submitted by the MCO. Each MCO's PIP was reviewed against all 27 components contained within the ten standards.

The results of the ten activities assessed for each PIP submitted by Optima Family Care (Optima) are presented in Table 2 below.

Table 2. 2004 Performance Improvement Project Review for Optima

Activity Number	Activity Description	Review Determination	
		Improving Treatment and Utilization Patterns for the Optima Health Management Diabetes Population	Improving Treatment and Utilization Patterns for the Optima Health Management Asthma Population
1	Assess the Study Methodology	Met	Met
2	Review the Study Question(s)	Met	Met
3	Review the Selected Study Indicator(s)	Met	Met
4	Review the Identified Study Population	Met	Met
5	Review Sampling Methods	Not Applicable	Not Applicable
6	Review Data Collection Procedures	Met	Met
7	Assess Improvement Strategies	Met	Met
8	Review Data Analysis and Interpretation of Study Results	Met	Met
9	Assess Whether Improvement is Real Improvement	Met	Met
10	Assess Sustained Improvement	Met	Met

Conclusions and Recommendations

Conclusions

Optima provided two PIPs for review. These included, Improving Treatment and Utilization Patterns for the Optima Health Management Diabetes Population and Improving Treatment and Utilization Patterns for the Optima Health Management Asthma Population. These were evaluated using the Validating Performance Improvement Projects protocol, commissioned by the CMS, which allows assessment among 10 different project activities.

For the Diabetes Project, the MCO received a review determination of "Met" for nine (9) elements, "Partially Met" for zero (0) elements, and "Unmet" for zero (0) elements. Activity five, Sampling Methods, was "Not Applicable" because sampling was not utilized.

For the second project, Improving Treatment for Asthma, Optima received a review determination of "Met" for nine (9) elements, "Partially Met" for zero (0) elements, and a review determination of "Unmet" for zero (0) elements. Activity five, Sampling Methods, was "Not Applicable" because sampling was not utilized.

Recommendations

Based on a review of each of the two PIPs provided by the MCO, the following recommendations are made to improve the PIP process and performance.

Improving Treatment and Utilization Patterns for the Optima Health Management Diabetes Population.

- Describe qualifications of staff/personnel used to collect the data in greater detail.

Improving Treatment and Utilization Patterns for the Optima Health Management Asthma Population

- Consider performing statistical significance testing for baseline and repeat indicator measurements.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: JAJ

Date of evaluation: 3/7/2006

Demographic Information
MCO/PHP Name or ID: Project Leader Name:
Telephone Number:
Name of Quality Improvement Project: Optima – Diabetes
Dates in Study Period: to: Phase:

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	Optima analyzed data, including prevalence rates for diabetes in their population. Diabetes rates increased by 11% overall and a 16% increase was noted in the 0-17 age group.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1 MMCD 2004
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	In addition to addressing six HEDIS Comprehensive Diabetes Care measures, the plan also seeks to decrease inpatient admissions and emergency department visit rates with a primary diagnosis of diabetes.	QAPI RE2Q1QI A S1A2 MMCD 2004
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	This PIP addresses care of all commercial and Medicaid HMO enrollees.	QAPI RE2Q1 QIA S1A2 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	With a high prevalence rate of diabetes, the plan seeks to improve testing rates and examinations related to diabetes care. By improving care, there should be a decrease in the number of inpatient admissions and emergency department visits.	QIA S1A3 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	The study indicators are clearly defined and measurable.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	The measures identified are valid proxies for improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	The MCO specified the population to which the study applies.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	The plan's data collection methodology included all eligible members in the study.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	N/A	Optima did not utilize sampling.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	N/A	Optima did not utilize sampling.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:			
5.3 Did the sample contain a sufficient number of enrollees?	N/A	Optima did not utilize sampling.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	The MCO's study design clearly specified the data to be used for all eight measures.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data?	Y	The plan's study design clearly specified the sources of data, as per HEDIS review and encounter/claims review.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	The MCO utilized HEDIS methodology in its study design for indicators 1-6; therefore, valid and reliable data is collected that represents the population being studied. For indicators 7 and 8, the study design appears to utilize a systematic method of collecting valid and reliable data. Data is collected (no manual entry) by Clinical and Business Intelligence. Analysis oversight of accuracy is conducted by defined members/committees.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	Y	The data collection methodology employed by the MCO provided for consistent, accurate data collection over the periods studied.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	N/A	N/A for remeasurement years.	QAPI RE5Q1.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 6. REVIEW DATA COLLECTION PROCEDURES
Describe qualifications of staff/personnel used to collect the data.

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	The MCO's interventions are targeted and address barriers identified. The diabetes program is being transitioned to a more coordinated approach for outreach and education of members and providers.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3 MMCD 02-04 MMCD 99-02 MMCD 99-07
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	Y	Numerical results were presented accurately and clearly.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	Y	The analysis included comparisons of the results to the goal and to the previous measurement year. No factors were cited that threatened validity or comparability.	QAPI RE7Q2 QIA S1C4 QIA S2.1 MMCD 2004
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	Y	The qualitative analysis addressed the success of each measure, including barriers, opportunities, and interventions.	QIA S2.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Y	There were no changes in methodology.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4 MMCD 2004
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	Y	Not all measures demonstrated improvement; however, there were several measures with documented improvement.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	Y	The improvements documented in the indicators measured were due to the interventions implemented by the MCO.	QIA S3.2 MMCD 2004
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	N/A	Statistical evidence is not required.	QIA S2.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	Y	Optima Family Care demonstrated sustained improvement since baseline for the LDL Control Rate.	QAPI RE2SQ3 QIA II, III MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths: The study indicators were clearly defined. Quantitative and qualitative analyses were comprehensive. Barriers and opportunities were addressed. Appropriate interventions were implemented.
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): Barriers identified include the lack of knowledge of both members and providers.
4. Action taken by MCO (Barrier Analysis): A comprehensive, coordinated diabetes program has been developed to address the identified barriers.
5. Recommendations for the next submission: • Describe qualifications of staff/personnel used to collect the data in greater detail.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: DMP

Date of evaluation: 2/28/2006

Demographic Information
MCO/PHP Name or ID: Project Leader Name:
Telephone Number:
Name of Quality Improvement Project: Optima – Asthma
Dates in Study Period: to: Phase:

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	Optima analyzed data including the Medallion II population which indicatd increases in the number of enrollees with asthma.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1 MMCD 2004
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	Optima seeks to decrease ER and hospital admission for asthma members along with increasing the use of appropriat asthma medications. This PIP addresses a broad spectrum of key aspects of enrollee care and services.	QAPI RE2Q1QI A S1A2 MMCD 2004
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e., did not exclude certain enrollees such as with those with special health care needs?	Y	For indicators 1 and 2, the eligible population is continuously enrolled Medicaid HMO enrollees with a primary diagnosis of asthma. For indicator 3, HEDIS specifications were used to define the eligible population.	QAPI RE2Q1 QIA S1A2 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	The goal of the program is to achieve improved patient self-management of the disease process which will lead to a decrease in the need to seek medical services for asthma, concurrently leading to an overall improvement in member's quality of life.	QIA S1A3 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	All indicators were objective, clearly defined, and based on current clinical knowledge. HEDIS specifications were used for one indicator.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	All three indicators have been identified as valid proxy measures for improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	Optima clearly defined all Medicaid enrollees for all three indicators to whom the study questions were relevant.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	The data collection approach captured all enrollees to whom the study question applied and was subject to the annual NCQA audit process.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	N/A	Optima did not use sampling in this study.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	N/A	Optima did not use sampling in this study.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:	N/A		
5.3 Did the sample contain a sufficient number of enrollees?	N/A	Optima did not use sampling in this study.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: This area of assessment is not applicable because Optima did not use sampling in this study.			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	The data to be collected was clearly specified for all three indicators.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data?	Y	Optima used claims/encournter and pharmacy data in this study.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	Data for all three indicators were subject to the annual NCQA audit process and has consistenly met the audit criteria. In addition, there were detailed procedures to ensure validity and reliability for indicator 3.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	Y	Data for all three indicators were subject to the annual NCQA audit process and has consistenly met the audit criteria.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	Y	A quantitative and qualitative analysis was included in the data analysis.	QAPI RE5Q1.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Y	The interventions were reasonable and focused on member and provider education as well as plan structure and systems.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3 MMCD 02-04 MMCD 99-02 MMCD 99-07
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	Y	Results were presented accurately and clearly including numerators and denominators for each indicator.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	Y	The analysis included comparisons of the results to the goal, baseline and previous remeasurement year. No factors were cited that threatened validity or comparability.	QAPI RE7Q2 QIA S1C4 QIA S2.1 MMCD 2004
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	Y	The qualitative analysis section for each indicator addressed the success of various interventiosn, barriers, opportunitites for improvement and interventions planned.	QIA S2.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Y	There were not changes in methodology from baseline to the current remeasurement year.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4 MMCD 2004
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	Y	The results for inpatient admissions remained the same, the number of ED visits were reduced by .9%, and the use of appropriate asthma medication decreased by 2.73%.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	Y	Improvement in performance appears to have face validity based upon the interventions that were developed and implemented to address identified barriers.	QIA S3.2 MMCD 2004
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	N/A	There were no statistical tests noted between remeasurement years 5 and 6.	QIA S2.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Consider performing statistical significance testing for baseline and repeat indicator measurements.			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	**Y**	There is evidence to support sustained improvement for all three indicators from baseline to remeasurement year 6.	QAPI RE2SQ3 QIA II, III MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths: Study indicators were objective and well defined. Barrier analysis identified system wide enrollee, provider, and administrative barriers. Data analysis was comprehensive for each indicator. Sustained improvement over the baseline measurement is evident.
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): Member and provider knowledge, member participation in self-management, timely identification of members, home health program not cost effective, staff education, health plan information, plan's inability to locate members, staff shortages, and communication to providers by plan.
4. Action taken by MCO (Barrier Analysis): Collaborative strategy developed with marketing staff to implement health awareness community workshops, hired full time asthma case manager, implemented electronic charting tool, entered into discussions with statewide home healthcare service provider, participated in a web conference to discuss way to enhance outcomes for asthma disease management program.
5. Recommendations for the next submission: • Consider performing statistical significance testing for baseline and repeat indicator measurements.

NCQA Quality Improvement Activity Form Instructions

Activity Name: Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population

Section I: Activity Selection and Methodology

A. Using objective information (data), how did you identify this activity for improvement? Why is it important to your members or practitioners?

Since 1994, diabetes has continued to be in the top ten diagnoses for the health plan for all claims by cost and volume. Predictive modeling is used by the health plan to further delineate quality improvement and disease management activities. Diabetes prevalence rates have increased across the state of Virginia, according to the Virginia Department of Health (Diabetes in Virginia, 2002), and prevalence rates continue to increase in ethnic groups, low income populations, and females. In CYE 2004, diabetes rates in the commercial population increased by 7% overall. In the Optima Family Care population, diabetes rates increased by 11% overall, and a 16% increase was noted in the 0-17 age population in Optima Family Care. Diabetes disproportionately affects ethnic groups such as African-Americans and Hispanics, is often under diagnosed or diagnosed late when vascular damage has already occurred. HEDIS data consistently demonstrates that the Medicaid population is significantly less likely to achieve desired outcomes of diabetes management. For these reasons, Optima has a responsibility and a commitment to providing disease management and coordination of care services to this population.

Quantifiable measures 1 – 6 are selected from HEDIS Comprehensive Diabetes Care. Hybrid data used for this QIA. Note: Hybrid measures for 2005 not available until July 2006.

Quantifiable measures 7 & 8 are selected from claims data. All members diagnosed with diabetes through coding, diabetes medication utilization, or diabetes-specific lab testing (A1c) during the evaluation period are included in this analysis. Data for these measures are collected by Clinical and Business Intelligence (CBI) and reported to the director of Disease Management, the Senior Medical Director, the Quality Improvement Committee, and the Physician Advisory Committee, who have the responsibility to analyze the data for accuracy, and develop interventions where appropriate. CBI is the department of Sentara Healthcare responsible for HEDIS data collection. There is no manual entry of data for these indicators.

B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed

Note: In each measure, commercial and POS members will be referred to as A, and Sentara Family Care members will be referred to as B

Quantifiable Measure #1:	Hemoglobin A1c Test Rate (Hybrid)
Numerator:	Total number of members having at least one A1c test during the measurement period
Denominator:	Total number of members identified with diabetes as per HEDIS criteria

Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark for CYE 2004:	Commercial: 83.49% Medicaid: 74.94%
Source of benchmark:	HEDIS 2004 Quality Compass
2004 goal:	Improve A1c Test Rate by 5% over previous year
Quantifiable Measure #2:	Retinal Eye Examination Rate (Hybrid)
Numerator:	Total number of members having dilated eye exam during the measurement period
Denominator:	Total number of members identified with diabetes as per HEDIS criteria
Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark:	Commercial: 45.93% Medicaid: 45.01%
Source of benchmark:	HEDIS 2004 Quality Compass
Baseline goal:	Improve retinal eye examination rate by 5% over previous year
Quantifiable Measure #3:	LDL Screening Rate (Hybrid)
Numerator:	Total number of members having LDL screening during the measurement period
Denominator:	Total number of members identified with diabetes as per HEDIS criteria
Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark:	Commercial: 87.88% Medicaid: 75.94%
Source of benchmark:	HEDIS 2004 Quality Compass
Baseline goal:	Improve lipid screening rate by 5% over previous year
Quantifiable Measure #4	LDL Control Rate (<130 mg/dL) (Hybrid)
Numerator:	Total number of members with LDL value < 130 mg/dL
Denominator:	Total number of members identified with diabetes as per HEDIS criteria

Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark:	Commercial: 61.07% Medicaid: 47.85%
Source of benchmark:	HEDIS 2004 Quality Compass
Baseline goal:	Improve % of members with LDL control < 130 mg/dL over previous year by 5%
Quantifiable Measure #5	Nephropathy Monitor Rate (Hybrid)
Numerator:	Total number of members with nephropathy monitored
Denominator:	Total number of members identified with diabetes as per HEDIS criteria
Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark:	Commercial: 46.73% Medicaid: 43.83%
Source of benchmark:	HEDIS 2004 Quality Compass
Baseline goal:	Improve nephropathy monitor rate by 5% over previous year
Quantifiable Measure #6	A1c Poor Control Rate (Hybrid)
Numerator:	Total number of members with A1c absent or > 9.5%
Denominator:	Total number of members identified with diabetes as per HEDIS criteria
Measurement period dates:	January 1 2000 through December 31, 2005
Benchmark:	Commercial: 30.89% Medicaid: 48.54%
Source of benchmark:	HEDIS 2004 Quality Compass
Baseline goal:	Improve poor A1c control rate by 5% over previous year
Quantifiable Measure#7	Number of Inpatient Admissions for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period)
Numerator:	Total number of inpatient hospital admissions for a primary diagnosis of diabetes
Denominator:	Total numbers of health plan members identified with diabetes through claims review

Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark:	None
Source of benchmark:	N/A
Baseline goal:	Improve inpatient admission rate/1000 for a primary diagnosis of diabetes by 5% over previous year
Quantifiable Measure #8	Number of emergency department visits for a primary diagnosis of diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period)
Numerator:	Total number of emergency department visits with a primary diagnosis of diabetes
Denominator:	Total numbers of health plan members identified with diabetes through claims review
Measurement period dates:	January 1, 2000 through December 31, 2005
Benchmark:	None
Source of benchmark:	N/A
Baseline goal:	Improve emergency department visits/1000 for a primary diagnosis of diabetes by 5% over previous year

C. Baseline Methodology

C.1 HEDIS/CAHPS®2.0H Methodology (*Note:* This element is not required.)

Was HEDIS/CAHPS® methodology used?

[X] Yes, for Measures 1 through 6

List the years used: All

List the HEDIS® measure and/or CAHPS®2.0H question numbers used and/or the composite questions used:

X __Comprehensive Diabetes Care Measures Hybrid

Skip to Section I D.

[X] No. If HEDIS/CAHPS® 2.0H methodology was not used, complete Section I C.2-6. For Measures 7 & 8

C.2 Data Sources Applies to Measures 7 & 8

[ ] Medical/treatment records
[ ] Administrative data:
[X] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach survey tool and attach the complete survey protocol)
[ ] Other (list and describe):

_____

_____

C.3 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology. Applies to Measures 7 & 8

If medical/treatment records, check below
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:
[X] Programmed pull from claims/encounter files of all eligible members Applies to Measures 7 & 8
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

C.4 Sampling. If sampling was used, provide the following information: Not Applicable

C.5 Data Collection Cycle Applies to Measures 7 & 8	Data Analysis Cycle Applies to Measures 7 & 8
[ ] Once a year [ ] Twice a year [ ] Once a season [X] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[X] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____

C.6 Other Pertinent Methodological Features. Complete only if needed.

Data for Quantifiable Measures 1 through 6 use HEDIS criteria. (Hybrid data)

Data for Quantifiable Measures 7 & 8 reflect continuously enrolled members during the data collections period who have any claim for one of the following: ICD-9 250 through 250.93, or 357.2, or 362.0, or 366.41

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement. Not applicable as there were no changes in methodology from measurement to measurement.

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure: Hemoglobin A1c Test Rate (Hybrid) A.= Commercial, B= Optima Family Care

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 596 B. 268	A. 769 B. 413	A. 77.50% B. 64.89%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 369 B. 326	A. 456 B. 473	A. 80.92% B. 68.92%			
1/1/02 through 12/31/02	Remeasurement 2:	A. 382 B. 344	A. 459 B. 456	A. 83.22% B. 75.44%			
1/1/03 through 12/31/03	Remeasurement 3:	A. 372 B. 303	A. 459 B. 412	A. 81.05% B. 73.54%			
1/1/04 through 12/31/04	Remeasurement 4:	A. 401 B. 334	A. 462 B. 455	A. 86.80% B. 73.41%	A .83.49 B. 74.94	A. 85.10% B. 77.21%	
1/1/05 through 12/31/05	Remeasurement 5: Hybrid data available July 2006	A. B.	A. B.	A. B.	A. B.	A. 88.53% B. 74.88%	

#2 Quantifiable Measure: Retinal Eye Examination Rate (Hybrid)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 462 B. 195	A. 769 B. 413	A. 60.08% B. 47.22%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 252 B. 238	A. 456 B. 473	A. 55.26% B. 50.32%			
1/1/02 through 12/31/02	Remeasurement 2:	A.246 B.210	A.459 B.456	A.53.59% B.46.05%			
1/1/03 through 12/31/03	Remeasurement 3:	A.216 B.157	A.459 B.412	A.47.06% B.38.11%			
1/1/04 through 12/31/04	Remeasurement 4:	A.223 B.191	A.462 B.455	A.48.27% B.41.98%	A. 45.93% B. 45.01%	A. 49.41% B. 40.02%	

1/1/05 through 12/31/05	Remeasurement 5: Hybrid data available July 2006	A. B.	A. B.	A. B.	A. B.	A. 49.23% B. 42.82%	

#3 Quantifiable Measure: LDL Screening Rate (Hybrid)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 538 B. 220	A. 769 B. 413	A. 69.96% B. 53.27%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 366 B. 273	A. 456 B. 473	A. 80.26% B. 57.72%			
1/1/02 through 12/31/02	Remeasurement 2:	A.384 B.328	A.459 B.456	A.83.66% B.71.93%			
1/1/03 through 12/31/03	Remeasurement 3:	A.382 B.304	A.459 B.412	A.83.22% B.73.79%			
1/1/04 through 12/31/04	Remeasurement 4:	A.418 B.328	A.462 B.455	A.90.48% B.72.09%	A. 87.88% B. 75.94%	A. 87.38% B. 77.48%	
1/1/05 through 12/31/05	Remeasurement 5: Hybrid data available July 2006	A. B.	A. B.	A. B.	A. B.	A. 92.29% B. 73.53%	

#4 Quantifiable Measure: LDL Control Rate (<130 mg/dL) (Hybrid)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 384 B. 128	A. 769 B. 413	A. 49.93% B. 30.99%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 256 B. 162	A. 456 B. 473	A. 56.14% B. 34.25%			
1/1/02 through 12/31/02	Remeasurement 2:	A.256 B.206	A.459 B.456	A.55.77% B.45.18%			
1/1/03 through 12/31/03	Remeasurement 3:	A.264 B.204	A.459 B.412	A.57.52% B.49.51%			
1/1/04 through 12/31/04	Remeasurement 4:	A.320 B.251	A.462 B.455	A.69.26% B.55.16%	A. 61.07% B. 47.85%	A. 60.39% B. 51.98%	

1/1/05 through 12/31/05	Remeasurement 5: Hybrid data available July 2006	A. B.	A. B.	A. B.	A. B.	A. 70.65% B. 56.26%	
#5 Quantifiable Measure: Nephropathy Monitor Rate (Hybrid)							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 350 B. 125	A. 769 B. 413	A. 45.51% B. 30.27%			A. None B. None
1/1/01 through 12/31/01	Remeasurement 1:	A. 187 B. 167	A. 456 B. 473	A. 41.01% B. 35.31%			
1/1/02 through 12/31/02	Remeasurement 2:	A.206 B.183	A.459 B.456	A.44.88% B.40.13%			
1/1/03 through 12/31/03	Remeasurement 3:	A.205 B.149	A.459 B.412	A.44.66% B.36.17%			
1/1/04 through 12/31/04	Remeasurement 4:	A.221 B.171	A.462 B.455	A.47.84% B.37.58%	A. 46.73% B. 43.83%	A. 46.89% B. 37.97%	
1/1/05 through 12/31/05	Remeasurement 5: Hybrid data available July 2006	A. B.	A. B.	A. B.	A. B.	A. 48.80% B. 38.33%	
#6 Quantifiable Measure: A1 Poor Control Rate (Hybrid)							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 332 B. 247	A. 769 B. 413	A. 43.17% B. 59.81%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 199 B. 305	A. 456 B. 473	A. 43.64% B. 64.48%			
1/1/02 through 12/31/02	Remeasurement 2:	A.148 B.222	A.459 B.456	A.32.24% B.48.68%			
1/1/03 through 12/31/03	Remeasurement 3:	A.156 B.177	A.459 B.412	A.33.99% B.42.96%			
1/1/04 through 12/31/04	Remeasurement 4:	A.132 B.216	A.462 B.455	A.28.57% B.47.47%	A. 30.89% B. 48.54%	A. 32.29% B. 40.81%	

1/1/05 through 12/31/05	Remeasurement 5: Hybrid data available July 2006	A. B.	A. B.	A. B.	A. B.	A. 27.99% B. 46.52%	

#7 Quantifiable Measure: Number of Inpatient Admissions for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 105 B. 105	A. 5,001 B. 1,113	A. 2.1% B. 9.4%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 106 B. 105	A. 5,597 B. 1,477	A. 1.9% B. 7.1%			
1/1/02 through 12/31/02	Remeasurement 2:	A. 93 B. 106	A. 5,783 B. 1,858	A. 1.6% B. 5.7%			
1/1/03 through 12/31/03	Remeasurement 3:	A.95 B.103	A.5,588 B.1,903	A.1.7% B.5.4%			
1/1/04 through 12/31/04	Remeasurement 4:	A.97 B.109	A.6,034 B.2,142	A.1.6% B.5.1%	N/A N/A	A. 1.61% B. 5.13%	
1/1/05 through 9/30/05	Remeasurement 5: 3RD qtr 2005	A. 70 B. 144	A. 5,021 B. 2,244	A. 1.4% B. 6.4%	N/A N/A	A. 1.56% B. 4.99%	

#8 Quantifiable Measure: Number of Emergency Department Visits for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/00 through 12/31/00	*Baseline:*	A. 110 B. 80	A. 5,001 B. 1,113	A. 2.2% B. 7.2%			
1/1/01 through 12/31/01	Remeasurement 1:	A. 106 B. 92	A. 5,597 B. 1,477	A. 1.9% B. 6.2%			
1/1/02 through 12/31/02	Remeasurement 2:	A. 121 B. 137	A. 5,783 B. 1,858	A. 2.1% B. 7.4%			
1/1/03 through 12/31/03	Remeasurement 3:	A.123 B.135	A.5,588 B.1,903	A.2.2% B.7.1%			

1/1/04 through 12/31/04	Remeasurement 4:	A.151 B.141	A.6,034 B.2,142	A.2.5% B.6.6%	N/A N/A	A. 2.09% B. 6.74%	
1/1/05 through 9/30/05	Remeasurement 5: 3rd QTR 2005	A.100 B.159	A.5,021 B. 2,244	A.2.0% B.7.1%	N/A N/A	A. 2.45% B. 6.46%	

* If used, specify the test, p – value, and the specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and the Measures the Analysis Covers.

1. Baseline: January 1 through December 31, 2005 Note: HEDIS hybrid available July, 2006—analysis will be completed when data available for measures 1-6. Interim analysis of 3rd QTR data for 6 and 7 provided below.

- Quantifiable measure #1 – A1c Test Rate (HEDIS) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #2 – Retinal Eye Exam Rate (HEDIS) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #3 – LDL Screening Rate (HEDIS) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #4 – LDL Control Rate (HEDIS) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #5 – Nephropathy Monitor Rate (HEDIS) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #6 - A1c Poor Control Rate (HEDIS) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #7 - Number of Inpatient Admissions for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period) for (A.) Commercial and (B.) Family Care (Medicaid) populations
- Quantifiable measure #8 - Number of Emergency Department Visits for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period) for (A.) Commercial and (B.) Family Care (Medicaid) populations

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

1. Baseline: January 1 through December 31, 2004

Measure #1: A1c test rate (A and B)

Quantitative: Compared to 2004 goal, A1c test rate in the commercial population was improved, and the goal was exceeded. The commercial population rate also exceeded that of the benchmark. The Optima Family Care goal was not met for CYE 2004, and remained below the benchmark.

Qualitative: Many members in both populations continue to be unaware of the importance of the A1c, and do not know their own results. Many members contacted by our clinical staff reported that they had never heard of the A1c, and consequently did not know to ask for this test to be done. Physicians in the Physician Advisory Committee and the Diabetes Advisory Committee continue to note that sometimes when random blood glucose was found to be high during the office visit, an A1c is deferred because it was expected to be high

Barrier: Knowledge deficit among members and practitioners regarding the importance of obtaining the A1c exam.

Opportunity: Educate members and practitioners about the need for regular A1c testing.

Intervention: Biannual reports for MD's showing % of members receiving A1c testing; PCP's with more than 20 diabetes members receive Diabetes Management Summary indicating % of members not receiving A1c's; all members identified with diabetes are sent Diabetes Owner's Manual cards identifying appropriate testing schedule. A physician office card indicating the appropriate testing schedule was also disseminated in mid 2004. Members not receiving A1c's in a one-year period are contacted by the program and educated about the value of having this test. The A1c is a covered benefit under all Optima products, and there is no barrier to having this test completed.

Measure #2: Retinal Eye Exam Rate (A and B)

Quantitative: Commercial Eye Exam Rate fell short of the Optima goal this period, although exceeded the benchmark.. The Optima Family Care population exceeded the current goal, although fell short of the benchmark. Goals for both populations were set at 5% improvement over previous year rates.

Qualitative: Members continue to be somewhat confused about the need for the yearly eye exam, and many state that they have no visual problems. The need for a referral from the PCP appears to be a barrier for many.

Barrier: SFC members may believe they will experience pain or vision loss as a warning before diabetes eye disease develops, and many find that getting a referral from the PCP to be a barrier to getting this test completed.

Opportunity: Members need education regarding the need and process for the diabetes eye exam. It was recommended to the Benefits committee in the fall of 2004 that the need for a referral from the PCP be discontinued. This was agreed to and for 2005 there will be not requirement for a referral from the PCP to have a dilated eye exam.

Intervention: Members identified with diabetes in SFC sent letter and educational material explaining need and process for obtaining diabetes eye exam. Members without eye exams receive calls from Optima Family Care Customer Service Representatives regarding the need for a yearly retinal exam. The need for a referral will not be a barrier in 2005.

Measure #3: LDL Screening Rate (A and B)

Quantitative: Compared to goals set for the commercial population, the LDL test rate exceeded both the benchmark and the goal in the commercial population. However, the LDL test rate fell short for the Optima Family Care population for both the benchmark and the goal. Goals were set at a 5% improvement over previous year rate.

Barrier: Noted through claims that most members do receive a total cholesterol during the year.

Opportunity: Members and practitioners need information regarding the importance of an LDL test for persons with diabetes

Intervention: Working with QI on the development of a larger effort to send information to members on the importance of an LDL. Working with selected employer groups on offering a "Know Your Numbers" Program to improve overall diabetes testing and clinical values. Diabetes disease management program was re-tooled in 2004 to include cardiovascular risks and expanded to include hypertension and hyperlipidemia.

Measure #4: LDL Control Rate (A and B)

Quantitative: Commercial population exceeded both Optima goal and benchmark. Optima Family Care population exceeded goal and benchmark. SHM goals were set at 5% improvement over previous year rate.

Barrier: Many members are unable to state their numbers during discussions with our telephonic management staff. They feel that their physicians should tell them if their results require action, and many with values greater than 130 mg/dL do not feel they were given any reason to be concerned. This is especially of concern given that the ADA goal for an LDL in diabetes is <100 mg/dL.

Opportunity: Member education on LDL control goal and supporting members to understand that they need to know their numbers and the goals for which they should be striving.

Intervention: Provide education through Know Your Numbers Program. Continue to emphasize to both members and practitioners the importance of measurement and control in the LDL goal.

Measure #5: Nephropathy Monitor Rate (A and B)

Quantitative: Commercial population exceeded Optima goal and benchmark on this measure. Optima Family Care, while improved over CYE 2003, did not meet goal or benchmark. SHM goals were set at 5% over previous year rate.

Qualitative: This issue continues to be discussed in Physician Advisory Committee (PAC) and Diabetes Advisory Committee This seems to be the most overlooked diabetes screening test. Members were asked about this test during telemanagement calls. They were generally unaware of the need for renal screening in diabetes. Most members expect that their MD's will know about and perform the necessary testing to manage the condition.

Barrier: General lack of knowledge regarding the need for Urine microalbumin testing in members and practitioners. Members appear to interpret any urine test as a test for diabetes renal disease.

Opportunity: Member and practitioner education on the diabetes tests needed.

Intervention: Urine testing is discussed in the "Know Your Numbers" program specific to the diabetes population. Letter sent to practitioners regarding the necessary diabetes tests and their compliance with testing.

Measure #6: A1c Poor Control Rate (A and B)

Quantitative: This goal was met and exceeded in the commercial population, both for the Optima goal and the benchmark. The Optima Family Population fell short both for the goal and the benchmark.

Qualitative: Substantial research shows that improvement in the A1c reduces development of diabetes complications. Discussions with members in the high-risk program reveals that many members do not know what an A1c is, and are not aware of their own A1c value, even when an A1c exists.

Barrier: Physicians report that often A1c's are not done because a member's blood glucose values run high. Some physicians report not

knowing if an A1c is a covered benefit under the health plan.

Opportunity: Opportunity exists to educate both MD's and members about the value of this test, and the fact that it is a covered benefit.

Intervention: Letters sent to MD's encouraging the use of A1c testing. Although HEDIS requires 1 A1c per year, SHM goal set at 2/year, and Chronic Disease Management Report is set to reflect the standard of members receiving more than 1 A1c per year. A1c testing and frequency is part of the Diabetes Know Your Numbers Program being dispersed in this year. Reports to MD's for the high-risk population, many of whom have A1c's greater than 9.0%, are developed to show all A1c values reported within a 1-year period. Members with A1c's greater than 9.0% are contacted by the Disease Management program for education on this indicator.

Measure #7: **Number of Inpatient Admissions for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period) for (A.) Commercial and (B.) Family Care (Medicaid) populations.**

Note: Analysis for 3rd QTR 2005—incomplete data set.

Quantitative: Commercial members demonstrate a 12% improvement in admissions in the 3rd quarter. Optima Family Care members demonstrate a 24% increase in admissions during this same period. OFC members with diabetes have increased 5% during this time period over previous year. OFC has expanded into new areas in 2005.

Qualitative: All members with a primary admission for diabetes are contacted though telemanagement, and this is a high priority for the disease management program. While not all members are reached telephonically, a letter is sent to those not reached, and a copy sent to the PCP, describing the benefits of working with the diabetes program to avoid diabetes complications and disease progression. Additionally, case managers coordinate with PCP's to determine an appropriate care plan and to encourage member adherence to plan. Diabetes education in the inpatient setting is largely unavailable except for survival skills, and the program seeks to facilitate members finding education programs in their areas, or offering the education telephonically.

Barrier: Hospitalized members are difficult to reach and may not be exposed to comprehensive diabetes education, or be aware of how to better manage their care. PCP's may be unaware of hospitalizations for primary diabetes problems.

Opportunity: As most hospitalizations for diabetes can be prevented, contacting members with diabetes admissions is a high priority for the program. Optima uses claims, pharmacy and lab data to identify and stratify members with diabetes, and a hospitalizations list is evaluated daily to identify those with primary diabetes admissions.

Intervention: Members and practitioners are contacted by the disease management program when a primary diabetes hospitalization occurs. Education is facilitated for the member, and the primary care physician is made aware of the problem. As noted in 2004, diabetes program is being transitioned to a more coordinated approach to cardiovascular metabolic disease in 2005. In the 1st qtr of 2005, a Team Coordinator was hired and trained to develop and transition the new team. In 2nd quarter, 3 new RN's were hired and trained to the new program. In 3rd quarter 2005, the diabetes program hired 2 Patient Advisor Representatives (PARs) who are non-healthcare professional coaches. These personnel contact the lower risk members to advise them on behaviors that can reduce diabetes risk factors, such as proper nutrition, exercise, and reminders about the need for appropriate testing. Finally, one additional PAR will be hired in the 4th quarter. It is projected that these new services will allow the program to contact more members, encourage better member adherence to treatment plans, promote improved behavior management and avert acute diabetes complications.

Measure #8: Number of Emergency Department Visits for a Primary Diagnosis of Diabetes (ICD-9 250 through 250.93, or 357.2, or 362.0 or 366.41 and continuously enrolled for the period) for (A.) Commercial and (B.) Family Care (Medicaid) populations

Note: Analysis for 3rd QTR 2005—incomplete data set.

Quantitative: ED utilization decreased in the commercial population by 17% in this period. ED utilization increased in the Optima Family Care population by 7% in this period.

Qualitative: Commercial and Optima Family Care members are identified as having a primary ED visit related to diabetes through claims data, which is updated monthly. As most diabetes-related ED visits can be prevented, the diabetes disease management program makes contacting these members a priority. If unable to be reached by phone, a letter is sent both to the member and the PCP, giving contact information for the program, and offering education and support.

Barrier: PCP's may be unaware of patients with a primary ED visit for diabetes. Reporting of a diabetes-related ED visit may take several months and "teachable moments" are lost. OFC members often require more coaching to encourage them to establish a medical home and may therefore utilize the ED as a primary care resource.

Opportunity: Since many emergency-type diabetes occurrences may be preventable through education, members and PCP's should be notified of diabetes program availability when these visits occur.

Intervention: Send diabetes program availability information to all members who have an ED contact, as well as trying to reach them telephonically. Notify PCP's by phone or by mail when a primary diabetes ED visit occurs. As noted in section on admission utilization, the program has been transitioning in 2005 to increase our ability to contact members and establish a relationship for coaching and behavior change related to diabetes risk.

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., hired 4 customer service reps as opposed to hired customer service reps). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers Interventions Address
01/94	X	Diabetes Multidisciplinary Task Force initiated. This has evolved into the Diabetes Advisory Committee (DAC), which includes community endocrinologists, nurse and dietitian CDE's, a pharmacist, a clergy member, community members with diabetes, and representatives from all Sentara hospital education programs. Diabetes Program Director for Sentara Health Management also serves as system diabetes program Coordinator. Function of committee is to develop and update diabetes guidelines, oversee the diabetes education programs for Sentara Healthcare, and offer guidance in diabetes program development. It was determined that no coordinated education programs existed in the community for ongoing diabetes education and management and this committee serves to develop, oversee and maintain American Diabetes Association Recognition for Sentara-based programs.	**Barrier: No organized strategy to address growing diabetes population and organization of care management.**
08/94	X	Diabetes Guidelines developed and mailed as part of Sentara Health Management provider guidelines. Updated annually. Guidelines were developed to offer accessible diabetes education and ongoing updates of diabetes standards of care to providers.	**Barrier: Physicians not generally aware of studies such as the DCCT showing the importance of tight blood glucose management.**

Fall/95	X	Diabetes Comprehensive education classes developed and offered through all Sentara hospitals. Members had no formal mechanism to receive comprehensive diabetes education, and MD offices were unable to provide same due to time constraints and lack of trained personnel in MD offices. Classes are both in group and individual format to allow for individualized education in comprehensive diabetes care. All SHM members with diabetes notified of classes through member educational materials.	**Barrier: Limited access and wide variation in available diabetes education and training for members who are diagnosed with diabetes.**
01/97	X	Diabetes Disease Management program developed within Sentara Health Management. Members identified through Health Risk Appraisal, case management and MD referral, utilization data, lab data and pharmacy data. Diabetes members had been identified only through hospitalization or significant complication prior to this initiative, which did not give opportunity to prevent diabetes complications.	**Barrier: Lack of organized program to identify members with diabetes and coordinate care.**
11/97	X	Diabetes Telemanagement program for SHM members initiated with trained diabetes intake coordinator. (0.5 FTE) Telemanagement coordinator contacts members determined to meet high risk criteria for evaluation and referral to appropriate resource (education, case management, PCP, etc.) High risk criteria are: • Inpatient admission for a primary diagnosis of diabetes (ICD-9 codes 250 – 250.93, or 357.2 or 362.0 or 366.41) OR 2 or more ED visits for a primary diagnosis of diabetes within a 6 month period, OR • They have 2 A1c's over 9.5% within a one year period OR 1 A1c over 9.5% and no other A1c result during that year, OR no A1c done during a 1 year period, OR • They are referred by a physician and determined through risk assessment to be high risk by behavior or educational needs.	**Barrier: Members determined to be high-risk require more intensive assessment and education, as well as repeated contact to affect behavior change.**

07/98	X	Diabetes Supplies Benefit initiated on a roll-in basis based on plan renewal date through Sentara Home Care. Diabetes self-testing meters, strips and lancets offered to members through this program. Members were not covered for diabetes testing supplies previous to this program. As a result, members were not generally aware of their diabetes control until blood testing done in the MD office. This program offered the opportunity to be more knowledgeable and responsible for diabetes management. Revised 10/00	**Barrier: Although diabetes program encouraged self-management testing, this was not generally a covered benefit, so members were often financially unable to comply with testing standards.**
07/98	X	Welcome calling program initiated for new members. Members who identify themselves as having diabetes receive information regarding diabetes education and supplies access through SHM.	**Barrier: Members may not be aware of diabetes disease management program and benefits.**
01/99	X	Physician Management Summaries developed and sent biannually to MD's with more than 10 SHM members identified as having diabetes. Reports identify how many SHM members with diabetes are in the MD panel, how many have an 1 A1c completed, the percent of diabetes members with a retinal eye exam , and the percent of diabetes members admitted or seen in the ED with diabetes as the primary diagnosis.	**Barrier: Physicians perception is that they follow American Diabetes Association guidelines of care although record audit and HEDIS data suggest that this is not the case.**
04/99	X	New Consult-and-Treat 12 month referral for diabetes established. This referral type allows for one referral to cover 12 months of specialist care such as podiatry, endocrinology and ophthalmology. Physicians notified of this through physician newsletter.	**Barrier: Member and practitioners were often unsure of coverage benefits for specialist referral.**
10/99	X	Developed annual diabetes retinal screening using non-mydriotic camera. Addresses member perceived difficulty in obtaining eye screening exam. Members who have not had an eye exam in an 18 month period are invited to screening. 161 members attended screening. Revised in 2001 to include BG testing, foot screening and education.	**Barrier: Many members continue to fail in obtaining dilated eye exam yearly.**

01/00	X	Educational booklets and cards on diabetes self-management developed and mailed to all members identified with diabetes. These tools comprise a comprehensive overview of diabetes and are written at a low literacy level to be accessible to all members. Tools also available at SMG physician sites. Some members note being unable to attend education classes due to conflicting schedules, although classes are offered during days and evenings. Tools are designed to offer a complete overview of diabetes for members. Those members with questions are encouraged to call in through telemanagement for further information.	**Barrier: Unable to find a consistent resource with comprehensive diabetes education in simple written format to send to members who request information.**
01/00	X	Diabetes educational videos made available through all Sentara hospitals on the hospital education system provided in patient rooms. Intervention designed to assist hospitalized members in accessing diabetes education.	**Barrier: Hospitalized members not consistently educated or aware of community or hospital-based educational services available to assist and support them in managing diabetes.**
01/00	X	Add training on SHM diabetes benefits to hospital Diabetes Resource Associate training program (offered biannually). Sentara Hospital units have designated Diabetes Resource Associates (DRA) who can distribute SHM diabetes program information and benefits information to hospitalized patients.	**Barrier: Hospital professional nursing staff requires support in staying current with diabetes management information.**
01/00	X	Developed report for MD's listing members who had no A1c in a 6 month period and/or no eye exam within one year. These reports sent to 300 PCP's biannually (January and June, 2000). Addresses issue of A1c testing and eye exams rates not meeting standards.	**Barrier: Physicians generally unaware of their members who are not compliant with these elements of diabetes testing.**
01/00	X	Developed two-hour educational program for Norfolk Consortium and Virginia Beach City and Schools population and offered program at 6 sites during the year. Meetings with these two employer groups reveal that some members report having difficulty attending comprehensive diabetes education classes due to length of classes (9 hours over a three-week period). Developed the two-hour program to offer the highlights of diabetes education to members who otherwise might not attend any education classes.	**Barrier: Norfolk Consortium interested in improving diabetes care for their members and requesting support from the health plan in doing so. Members have reported time constraints in attending the comprehensive diabetes classes available throughout the community.**

01/00	X	Diabetes Advisory Committee agreed to adopt the Texas Diabetes Pharmacologic Algorithm for inclusion in the diabetes guidelines. A copy of the algorithm and a letter was sent to SHM PCP's. Addresses practitioner educational needs for decision path regarding diabetes oral agents and insulins.	**Barrier: No system consensus on when and how to introduce diabetes pharmacological interventions.**
01/00		Developed two-hour educational program taught on-site at SHM for SFC population. Discussions with SFC members in the telemanagement program suggest that they do not attend comprehensive education classes due to the length and complexity of the information taught. SFC members meeting high risk criteria are offered the opportunity to attend the two-hour class onsite at SHM. Transportation is provided.	**Barrier: SFC members often do not attend comprehensive classes. Some members have noted to telephonic staff that classes are complication and inaccessible.**
01/00		Sentara Family Care members with no documentation of a dilated eye exam are contacted by Customer Service Representatives to explain the importance of having an eye exam and to assist the member in obtaining a referral to have the eye exam completed. This is done quarterly as data are gathered. SFC members often benefit from support and assistance in getting this exam completed.	**Barrier: SFC members are less likely to have a yearly dilated eye exam than the commercial population, and seem to be less informed about diabetic retinopathy.**
3/00	X	Professional staff (RN's in Home Care and Case Managers) education offered 3 times during the year regarding changes to diabetes guidelines, treatments and medications. Home Care nurses and SHM nurse case managers noted that they had limited access to diabetes update information.	**Barrier: Home care staff and SHM case managers have difficulty getting updates in diabetes treatment and management information.**

10/00	X	Began contracting with National Diabetic Pharmacies as the provider of diabetes testing supplies. Meters, strips and lancets, as well as pump supplies and diabetes medications can be distributed from NDP for member ease. Complaints about supplies not arriving in a timely manner and increased costs through Sentara Home Care necessitated a change in contracting. National Diabetic Pharmacies was able to provide meters free as well as improved strip pricing. In addition, NDP has nurse CDE's available by phone Monday through Friday from 8 am to 5 pm, for members to call with diabetes questions, which expands our ability to offer telephonic support. NDP also agreed to send quarterly reports to SHM regarding member compliance with testing based upon MD order, and this information is added to our diabetes registry database.	**Barrier: Current vendor for diabetes supplies unable to meet program needs and requested rate increase.**
10/00	X	Diabetes information made available on www.Sentara.com and www.Optima.com on the web. Diabetes information availability to members who like to receive information through web browsing.	**Barrier: Information technology noted members were requesting diabetes information on the SHC and Optima web sites.**
01/01	X	Initiated pilot project in MD office designed to develop and implement processes leading to improved routine diabetes testing compliance and member education and behavior change. Project name is "Diabetes LifeCoach." Analysis of 2000 year end data by Physician Advisory Committee, and Disease Management Program team suggests that a more organized structure within a PCP practice may be necessary to improve these outcomes. Physician was selected from data through predictive modeling software as having a high risk population. A nurse CDE is offered to this practice 1 day weekly, and also offers telephonic coaching and follow up to these members.	**Barrier: Lack of organized structure within the busy primary care practice office to address diabetes in a complete and comprehensive manner.**
02/01		Diabetes Advisory Committee developed the Diabetes Mini-Consult which gives information of acute management issues in diabetes care. Mini-consult mailed to SHM PCP's. Addresses practitioner need for regular updates regarding diabetes medication management.	**Barrier: Practitioners expressing interest in acute management of diabetes including insulin management and coordination of medications with steroids, TPN, etc.**

02/01	X	Developed, offered and taught quarterly educational programs to Norfolk Consortium, and throughout the Hampton Roads community entitled, "Know Your Numbers." This program is targeted to diabetes patients and encourages them to be knowledgeable about the following aspects of diabetes care: blood glucose and A1c testing, BP, cholesterol and LDL numbers, urine testing for microalbuminuria, and the diabetes eye exam. Program was taught quarterly to Norfolk Consortium and at fifteen community sites during the year. Members were invited either by being part of the Norfolk Consortium, or through letters sent to selected members within program zip codes.	**Barrier: General lack of information about the growing issue of dysmetabolic syndrome and the importance of managing glucose, blood pressure and hyperlipidemia in diabetes.**
03/01	X	All Sentara hospitals, case managers and diabetes educators included in a Consignment Meter program for health plan members through National Diabetes Pharmacies. This program allows hospitals, case managers and educators to immediately give a meter to a newly diagnosed member, thereby ensuring instant access to the tools. Over 600 meters distributed during the year through this program.	**Barrier: Members had to wait several days after being trained on a blood glucose meter before the meter could be shipped from National Diabetic Pharmacies.**
05/01 – 09/01		Presented "Is Your Number Up?" campaign to Sentara leadership committees and physicians throughout Hampton Roads. Campaign is designed to support all members (not just with diabetes) in increasing awareness of blood pressure and lipid guidelines.	**Barrier: Data suggest that decision-makers and practitioners are not aware of current blood pressure and lipid guidelines.**
05/01 – 12/01	X	Mass community cholesterol and BP screenings at churches, YMCA sites, and Community Centers. Provided educational materials and counseling to all at risk participants. Health plan members notified of screening times and dates and encouraged to participate.	**Barrier: Members unaware of cholesterol and BP values.**
07/01	X	Received ongoing American Diabetes Association Recognition for all Sentara Healthcare diabetes education programs. Insures that education programs offered by any Sentara facility meet National Recognition Standards.	**Barrier: ADA Recognition addresses quality and standardization of diabetes information to insure effective program.**

08/01		179 PCP providers and 563 members received information about the SHM diabetes disease management program. PCP's received a copy of the Diabetes Flow Sheet for tracking members tests in their medical record, and members received a copy of the Diabetes Owner's Manual and the wallet card. Purpose of intervention was to inform PCP's and members in the SHM expansion areas about the SHM diabetes program and benefits.	**Barrier: SHM expansion area (across Virginia) not aware of diabetes disease management program offered by SHM.**
09/01		Launched "Is Your Number Up?" campaign which included newspaper ads and articles, radio ads, postcard inserts in local newspapers, postcard mailings to SHM members, and educational materials through 1-800-SENTARA phone line. Although not limited to SHM population, SHM diabetes members were targeted for all these activities with a letter reminding them of their higher risk for complication and co-morbid disease.	**Barrier: Continued educational program designed to address lack of consumer knowledge regarding hypertension and hyperlipidemia.**
10/01		Distributed educational packets for "Know Your Numbers" campaign to MD offices. Packets included "Get To Goal" cards, "Do You Know Your Numbers?" posters, "Cholesterol Highway" flyers, and "How to Read a Food Label" flyers. SHM diabetes members received through mail the "Diabetes Owner's Manual" goal cards and the "How to Read a Food Label" flyer.	**Barrier: Lack of knowledge in members that they need to be aware and responsible for knowing the values of test results and the regular need for testing to be done.**
10/01	X	Offered the diabetes eye screening to members with no evidence of a dilated exam during an 18 month period. 71 members attended this screening. This year, the screening included not only the eye screening photography, but blood glucose testing at the site, meter training and meters to any members who did not have one, BP screening, foot risk screening, and nurse CDE's to answer any diabetes-related questions.	**Barrier: Continued low rates of dilated eye exams in the SHM population.**
11/01		Educational packets for the "Know Your Numbers" campaign distributed to 15 minority churches in the Hampton Roads community.	**Barrier: Lack of knowledge in members that they need to be aware and responsible for knowing the values of test results and the regular need for testing to be done.**

01/02	X	Website link to LODEC (Lilly Online Diabetes Education Center) made available through Sentara.com and optima.com. Letter sent to 8,200 diabetes members informing them of this new educational tool and instructing them on accessing the site. Many members like to receive educational information via web and this sites gives an interactive opportunity for members to learn more about diabetes self-management.	**Barrier: Continued general lack of knowledge about diabetes self-management.**
02/02	X	Data from Diabetes LifeCoach office project available and reviewed by diabetes disease management team. Data show marked improvement when LifeCoach model offered in this MD office. Plan to identify other offices using predictive modeling and expand program. Added LifeCoach criteria to high-risk definitions for disease management programming. Received authorization to increase program staff to support expansion.	**Barrier: Diabetes LifeCoach program demonstrated improtant results in the pilot year. Lack of resources made it impossible to expand program.**
06/02		Post-prandial glucose monitoring brochure which discusses the importance of after-meal evaluation of blood glucose sent to 4,500 members with documented A1c's over 8% within the past year. Purpose of mailing was to address the importance of post meal glucose monitoring as a method to evaluate meal size and composition as well as effect of meals on blood glucose.	**Barrier: Members not informed regarding the importance and value to performing post-prandial blood glucose monitoring.**
06/02		Three presentations offered to PCP's in Hampton Roads area related to managing type 2 diabetes patients. Sessions were conducted by local endocrinologists. Attempted to address the barrier of PCP knowledge related to ADA standards of care for diabetes. PCP's were invited based on specific practice patterns. Sessions were very poorly attended and program will not be offered further.	**Barrier: Data continue to demonstrate that physicians are not treating diabetes as aggressively as standards of care describe.**
07/02	X	Hired RN CDE to expand LifeCoach program to a total of 23 MD offices/1500 members. MD's identified through predictive modeling. The LifeCoach pilot showed dramatic improvement in an MD office where a nurse educator coached members to receive necessary testing and improve their diabetes self-management skills.	**Barrier: Despite frequent and repetitive educational efforts, program continues to note difficulty in members getting recommended testing in a timely manner.**

11/02	X	Diabetes eye screening offered to members with no dilated eye exam within an 18 month period. As in 2001, screening included eye photography, BP screening, BG screening, high risk foot screening, education and meter training and distribution to members. 98 members screened.	**Barrier: Continued low rates of dilated eye exams in the SHM population.**
2/03	X	Annual diabetes plan developed. Continue to educate both patients and practitioners regarding needed components of diabetes standards of care as developed by the American Diabetes Association. Utilize a combination of claims, lab and pharmacy data, as well as predictive modeling to identify, stratify, outreach and intervene with patients and practitioners.	
2/04	X	Annual diabetes plan developed. Continue to educate both patients and practitioners regarding needed components of diabetes standards of care as developed by the American Diabetes Association. Utilize a combination of claims, lab and pharmacy data, as well as predictive modeling to identify, stratify, outreach and intervene with patients and practitioners. Additionally, plan to develop business case and budget to re-organize diabetes program into more patient-centric Cardiovascular/Metabolic Disease (CVM) Management Program, to focus on identification and prevention of all cardiac risk factors, inclusive of diabetes. As many patients have the combination of hypertension, hyperlipidemia and diabetes, putting them at high risk for subsequent cardiovascular events, this is thought to be a more comprehensive way to manage these patients	
10/04		CVM Disease Management Program approved. Position for Team Coordinator posted. This team will include the Team Coordinator, 5 RN's with CVM background and experience, and 4 Patient Advisor Representative's to contact patients regarding the importance and timing of appropriate testing.	

2/05		TC hired for CVM Disease Management Program. This position and the current staff (3 RN's) began work on organizing the diabetes program into a more coordinated approach to CVM disease, of which diabetes is one component.	**Barrier: Members with diabetes often have complex metabolic and cardiovascular risk issues. Reorganizing the program to address diabetes, hypertension, hyperlipidemia, cardiovascular risk, and acute cardiovascular events will improve coordination of care.**
5/05		3 new RN FTE's hired to expand program and coverage.	
7/05	X	Revised process for obtaining the diabetes eye exam. No referral now needed to have the annual dilated eye exam. Members not having the annual exam are identified and contacted on a monthly basis by PAR's to remind them of the importance of the exam, and to explain the benefit change. PARs contact members and assist them in scheduling appointments with appropriate providers.	**Barrier: Many members and MD's were unaware that a member with diabetes could and should have an annual diabetes dilated eye exam. Because the standard benefit for eye care is an exam every other year, many thought the insurance would not cover the annual diabetes exam, which was incorrect. By eliminating the referral, and by contacting members individually, it is projected that more eye exams will be completed.**
8/05		2 new Patient Advisor Representatives hired and trained	

NCQA Quality Improvement Activity Form Instructions

Activity Name: Improving Overall Treatment and Utilization Patterns for the Sentara Health Management Asthma Population	
Section I: Activity Selection and Methodology	
A. Using objective information (data), how did you identify this activity for improvement? Why is it important to your members or practitioners?	
Within the Optima Health (Sentara Health Management) population there has been a gradual increase in the number of identified asthma members for all lines of business between the years 1999 and 2004. In 1999, members identified with asthma comprised 2.2% of total members enrolled in the health plan for that year. This number rose to 2.3% of the total health plan membership in 2000, and increased to 2.6% and then to 2.8% in 2001 and 2002, respectively. 35% of all inpatient hospital admissions for respiratory related diseases were due to asthma in 2000, and 33% of respiratory related admissions were due to asthma in 2001. Because asthma is a chronic disease which these members would be suffering some impact from in varying degrees for the rest of their lives, Optima Health took the approach that teaching members how to manage the disease on their own, with support and guidance from their health care team, was the best approach to optimizing their overall health and quality of life. Specifically in the Medicaid population, the number of members with asthma has increased by 20% between 2002 and 2003, and increased another 10% between 2003 and 2004. Program outcomes measured to reflect program efficacy include: hospital admissions per 1000 asthma members for a primary diagnosis of asthma, Emergency Department visits/1000 members with asthma for a primary diagnosis of asthma and use of appropriate medications for members with asthma (HEDIS measure). Each one of these measures has improved gradually over the years in which this program has been in existence. The overall improvement in these indicators would suggest that a focused intervention that encourages self-management techniques and greater member involvement in their own care can promote positive health outcomes in the targeted population. The data collected prior to program implementation in all mentioned indicators, and subsequent improvement with intervention, imply that these members were not effectively managing their asthma prior to program participation. This increase made it clear that this member group in specific would benefit greatly form ongoing intervention and education. It became apparent that the program, which had been implemented in 1997, should continue to be an integral part of the services offered by Optima Health (Sentara Health Management). Through education of both members and practitioners the goal of the program is to achieve improved patient self-management of the disease process. This will lead to a decrease in the need to seek medical services for asthma, concurrently leading to an overall improvement in the member's quality of life.	
B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed	
Quantifiable Measure #1:	Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for A. Commercial and POS Members B. Family Care Members (Medicaid) NOTE: Commercial and POS members will be referred to as A and Family Care (Medicaid) members will be referred to as B in the remainder of this document.
Numerator:	Total number of inpatient hospital admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for A& B
Denominator:	Health plan members identified with asthma through claims review for A & B

First measurement period dates:	January 1 through December 31, 1999
Benchmark:	N/A
Source of benchmark:	N/A
Baseline goal:	Decrease inpatient admissions for a primary diagnosis of asthma for a 5% improvement.
Quantifiable Measure #2:	Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for A & B
Numerator:	Total number of emergency department visits for a primary diagnosis of asthma for A & B
Denominator:	Health plan members identified with asthma through claims review for A & B
First measurement period dates:	January 1 through December 31, 1999
Benchmark:	N/A
Source of benchmark:	N/A
Baseline goal:	Decrease emergency department visits for a primary diagnosis of asthma for a 5% improvement.
Quantifiable Measure #3:	Use of Appropriate Medications for People with Asthma (HEDIS Measure) for A & B
Numerator:	Number of health plan members with asthma receiving appropriate asthma medications as defined by HEDIS 2000 measure for A & B
Denominator:	Number of health plan members with asthma for A & B
First measurement period dates:	January 1 through December 31, 1999
Benchmark:	Not available for 1999 and 2000. For 2001 for A only: QualChoice VA
Source of benchmark:	NCQA Quality Compass 2001
Baseline goal:	Increase the use of appropriate medications by members with asthma for a 5% improvement.

C. Baseline Methodology

C.1 HEDIS/CAHPS®2.0H Methodology (*Note:* This element is not required.)

Was HEDIS/CAHPS® methodology used?

[X] Yes. HEDIS methodology was used for Quantifiable Measure #3 as listed above.
List the years used: _1999, 2000 , 2001, 2002, 2003, 2004

List the HEDIS® measure and/or CAHPS®2.0H question numbers used and/or the composite questions used: _Use of Appropriate Medications for People with Asthma

Skip to Section I D.

[X] No. If HEDIS/CAHPS® 2.0H methodology was not used, complete Section I C.2-6. HEDIS/CAHPS 2.0H methodology was not used for Quantifiable Measures # 1 and #2.

C.2 Data Sources- Applies to Quantifiable Measures # 1 and #2

[ ] Medical/treatment records
[ ] Administrative data:
[X] Claims/encounter data for Quantifiable Measures #1 and #2 [ ] Complaints [ ] Appeals [ ] Telephone service data [[ ] [
[ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach survey tool and attach the complete survey protocol)
[ ] Other (list and describe):

_____

_____

C.3 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology. Applies to Quantifiable Measures #1 and #2.

If medical/treatment records, check below
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:
[X] Programmed pull from claims/encounter files of all eligible members for Quantifiable Measure #1 and #2
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[X] Pharmacy data- Quantifiable Measure #3
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

C.4 Sampling. If sampling was used, provide the following information: Not Applicable			
Measure	Sample Size	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.5 Data Collection Cycle- For Quantifiable Measures #1 and #2	Data Analysis Cycle- For Quantifiable Measures #1 and #2
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [X] Continuous [ ] Other (list and describe): _____ _____	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [X] Continuous [ ] Other (list and describe): _____ _____

C.6 Other Pertinent Methodological Features.

Data for Quantifiable Measures #1 and #2 reflect continuously enrolled members with a primary diagnosis of asthma using ICD9 diagnosis codes 493 through 493.92. Data is calculated using a rolling year average.

Data for Quantifiable Measure #3 is based on the percentage of continuously enrolled members with asthma in the prior year that received an appropriate prescription in the reporting year. For this measure Asthma is defined as a member who meets one of the following criterion in the prior year:

- 4 or more asthma medication dispensing events
- 1 or more Emergency Department visits for asthma
- 1 or more inpatient admissions for asthma
- 4 outpatient visits AND 2 or more asthma Rx dispensing events

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
- Any introduction of bias that could affect the results

There were no changes in baseline methodology.

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure: Number of Inpatient Admissions for a Primary Diagnosis of Asthma (ICD9 493.0-493.92)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/1999 through 12/31/1999	*Baseline:*	A. 113 B. 142	A. 3907 B. 2587	A. 2.9% B. 5.5%		A. 2.09% B. 5.42%	A. Chi-square R3 to baseline: p=0.001 Chi-square R3 to R2: p=0.100 B. Chi-square R3 to baseline: p=0.010 Chi-square R3 to R1: p=0.050
1/1/2000 through 12/31/2000	Remeasurement 1:	A. 84 B. 164	A. 3511 B. 3292	A. 2.4% B. 5.0%		A. 2.76% B. 5.23%	
1/1/2001 through 12/31/2001	Remeasurement 2:	A. 88 B. 190	A. 3848 B. 4139	A. 2.3% B. 4.6%		A. 2.28% B. 4.75%	
1/1/2002 through 12/31/2002	Remeasurement 3:	A. 67 B. 187	A. 3926 B. 4675	A. 1.7% B. 4.0%		A. 2.18% B. 4.37%	
1/1/2003 through 12/31/2003	Remeasurement 4:	A. 77 B. 253	A. 3339 B. 5741	A. 2.3% B. 4.4%		A. 1.62% B. 3.8%	
1/1/2004 through 12/31/2004	Remeasurement 5:	A. 55 B. 258	C. 3209 D. 6288	A. 1.7% B. 4.1%		A. 2.18% B. 4.18%	
1/1/2005 through 9/30/05	Remeasurement 6:	A. 43 B. 245	A. 2542 B. 6129	A. 1.7% B. 4.0%		A. 1.61% B. 3.9%	

#2 Quantifiable Measure: Number of Emergency Department Visits for a Primary Diagnosis of Asthma (ICD9 493.0- 493.92)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/1999 through 12/31/1999	*Baseline:*	A. 461 B. 673	A. 3907 B. 2587	A. 11.8% B. 26.2%		A. 9.8% B. 20.5%	A. Chi-square R2 to baseline: p=0.100 B. Chi-square R1 to baseline: p=0.001 Chi-square R2 to baseline: p=0.001 Chi-square R2 to R1: p=0.010
1/1/2000 through 12/31/2000	Remeasurement 1:	A. 379 B. 698	A. 3511 B. 3292	A. 10.8% B. 21.2%		A. 11.21% B. 24.89%	
1/1/2001 through 12/31/2001	Remeasurement 2:	A. 404 B. 757	A. 3848 B. 4139	A. 10.5% B. 18.3%		A. 10.26% B. 20%	
1/1/2002 through 12/31/2002	Remeasurement 3:	A. 455 B. 935	A. 3926 B. 4675	A. 11.6% B. 20.2%		A. 10.0% B. 17.4%	
1/1/2003 through 12/31/2003	Remeasurement 4:	A. 357 B. 1280	A. 3339 B. 5741	A. 10.7% B. 22.3%		A. 11.0% B. 19.2%	

1/1/2004 through 12/31/2004	Remeasurement 5:	A. 337 B. 1302	A. 3209 B. 6288	A. 10.5% B. 20.7%		A. 10.17% B. 21.18%	
1/1/2005 through 9/30/2005	Remeasurement 6:	A. 244 B. 1269	A. 2542 B. 6129	A. 9.6% B. 20.7%		A. 10.0% B. 19.7%	

#3 Quantifiable Measure: Use of Appropriate Medications for People with Asthma (HEDIS)

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Current Benchmark	Current Goal	Statistical Test and Significance*
1/1/1999 through 12/31/1999	*Baseline:*	A. 869 B. 590	A. 1548 B. 1003	A. 56.14% B. 58.82%	Not available for 1999	Not measured in previous year	A. Chi-square R2 to baseline: p=0.001 B. Chi-square R2 to baseline: p=0.001
1/1/2000 through 12/31/2000	Remeasurement 1:	A. 1073 B. 707	A. 1752 B. 1151	A. 61.24% B. 61.42%	Not available for 2000	A. 58.94% B. 61.72%	
1/1/2001 through 12/31/2001	Remeasurement 2:	A. 1148 B. 1104	A. 1836 B. 1628	A. 62.53% B. 67.81%	A. 71.31% B. N/A	A. 64.24% B. 64.42%	
1/1/2002 through 12/31/2002	Remeasurement 3:	A. 1145 B. 1350	A. 1732 B. 1939	A. 66.11% B. 69.62%	A. N/A B. N/A	A. 65.65% B. 71.21%	
1/1/2003 through 12/31/2003	Remeasurement 4:	A. 986 B. 1388	A. 1433 B. 2034	A. 68.81% B. 68.24%	A. N/A B. N/A	A. 69.41% B. 73.02%	
1/1/2004 through 12/31/2004	Remeasurement 5:	A. 1054 B. 1793	A. 1470 B. 2650	A. 71.70% B. 67.66%	A. N/A B. N/A	A. 72.25% B. 71.64%	
1/1/2005 through 9/30/2005	Remeasurement 6:	A. 958 B. 2106	A. 1389 B. 3066	A. 68.97% B. 68.69%	A. N/A B. N/A	A. 71.70% B. 67.66%	

- If used, specify the test, p – value, and the specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

For indicators #1 and #2 (Admissions/1000 and ED visits/1000) valid Medicaid enrollees are selected from the HEDIS Continuous Enrollment datamart. In order to be included in the measure, each enrollee must be continuously enrolled in Optima's Medicaid line of business for 12 months during the reporting period. These measures, along with measure #3, are subject to selection for audit during the annual NCQA audit process. The data analysis process has consistently met audit criteria.

For the baseline measures, data are collected from Optima's claims data warehouse (Product Modeling). The claims data included in the measure have been processed and paid, ensuring that the information submitted on each claim is clear and valid. Baseline utilization reporting is processed no earlier than 90 days after the reporting period to allow for the most complete analysis of the reporting period possible. Baseline measures are reviewed and validated by an Information Architect from Clinical and Business Intelligence (CBI) and clinical staff within the disease management program. The lead CBI Information Architect responsible for collecting information for the baseline measures has over 10 years of technical experience in the healthcare setting, with the last 6 years specifically in the Disease Management area.

The data used for the analysis of indicator #3 are mined and evaluated by the Information Architects within Sentara's Clinical and Business Intelligence division. Upon initial processing of pharmacy claims, the validity and reliability of the core data repository is extensively evaluated for scope and completeness of information through trending against historical data and tying it back to the stated total from a pharmacy data warehouse. The data are then transferred to a product modeling system from which Access databases are constructed and used to query the data in accordance with NCQA/HEDIS parameters. A team of Information Architects crosschecks each measure against previous time periods and established benchmarks. The Information Architects performing the data analysis are professional data analysts with varying credentials that specialize in healthcare data. Many of the Information Architects have previous experience in a health care environment such as hospitals, pharmacies, or managed care. Their key function is to facilitate IT solutions sets that support clinical, financial and operational initiatives within the health plan. They also are responsible for providing research and statistical modeling support through development, integration, implementation, and ongoing improvement of automated information systems for maximum information efficiency.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and the Measures the Analysis Covers.

1. Baseline: January 1 through December 31, 1999

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD 493.0-493.92) for population (A) Commercial and POS and (B) Family Care (Medicaid).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for population (A) Commercial and POS and (B) Family Care (Medicaid)

C. Quantifiable Measure #3- Use of Appropriate Medications for People with Asthma (HEDIS) for population (A) Commercial and POS and (B) Family Care (Medicaid).

2. Remeasurement 1: January 1 through December 31, 2000

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for Population (A) Commercial and POS and (B) Family Care (Medicaid).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for population (A) Commercial and POS and (B) Family Care (Medicaid)

C. Quantifiable Measure #3- Use of Appropriate Medications for People with Asthma (HEDIS) for population (A) Commercial and POS and (B) Family Care (Medicaid)

3. Remeasurement 2: January 1 through December 31, 2001

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

C. Quantifiable Measure #3- Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B).

4. Remeasurement 3: January 1 through December 31, 2002

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for

populations (A) and (B).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

C. Quantifiable Measure#3- Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B).

5. Remeasurement 4: January 1 through December 31, 2003

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

C. Quantifiable Measure #3- Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B).

6. Remeasurement 5: January 1 through December 31, 2004

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) For populations (A) and (B).

C. Quantifiable Measure #3- Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B).

7. Remeasurement 6: January 1 through September 30, 2005

A. Quantifiable Measure #1- Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

B. Quantifiable Measure #2- Number of emergency department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B).

C. Quantifiable Measure #3- Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B).

1. Remeasurement #1: January 1 through December 31, 2000

Measure #1: Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The admission rate for population (A) for this time period was 2.4% and for population (B) was 5.0%. Both populations exceeded the goal for this measure set at a 5% decrease from the previous year. There were no changes to the goals for this measure. The percent of inpatient admissions in the previous year was measured at 2.9% for (A) and 5.5% for (B). The trend for inpatient admissions for both populations decreased, improving outcomes by 17% for population (A) and 9% for population (B), exceeding the goal set at a 5% decrease for both.

Qualitative: All members admitted to the hospital for a primary diagnosis of asthma receive educational interventions designed to assist in increasing self awareness of their disease process and enhance self management techniques. Members in the local areas are referred to the home health Life Coach program for one on one educational intervention. Members in the expansion areas receive telephonic case management, and all members receive educational mailings. In addition, the primary care physicians receive notification of the member's enrollment in home health/telephonic case management programs, along with patient specific utilization profile with a reminder that inhaled anti-inflammatory medications are recommended for any persistent form of asthma.

Barriers: Locating members to participate in the Life Coach program has been difficult at times. Addresses and telephone numbers available are often incorrect, as population (B) tends to be transient. Occasionally members also refuse participation in the program, often indicating that they do not need this type of intervention, incorrectly assessing that their disease process is under adequate control.

Physician practice patterns have been slow to change, there are still a great many more prescriptions written for quick relief medications as opposed to preventative medications.

Many new members are joining the health plan through the expansion efforts. The home health program will not be available to these members until agencies can be identified in these areas that would want to administer this program. Until that happens, these members will be managed telephonically.

Opportunity: Continue to refer high risk members to home health Life Coach program, increase efforts to obtain accurate telephone numbers and addresses.

Explore opportunities to provide home health Life Coach program to growing membership in expansion areas.

Provide physicians with continual reminders of guideline recommendations for the appropriate treatment for asthma and individual patient reports.

Intervention: Continue referrals to Life Coach program and telephonic case management as described. Provide closed circuit asthma education on the hospital education channels. Asthma education has been added to the standard orders for asthma admissions in the Sentara Hospitals, to be performed by hospital nursing/respiratory staff during hospital admission. Notify primary care providers by mail when member is admitted and review utilization profile.

Measure #2: Number of Emergency Department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The emergency department visit rate for (A) for this time period was 10.8% and for (B) was 21.2%. Both populations exceeded the goal for this measure set at a 5% decrease from the previous year. There were no changes to the goals. The percent of emergency department visits in the previous year was measured at 11.8% for (A) and 26.2% for (B). The trend for emergency department visits for both populations decreased, improving outcomes by 8.5% for (A) and by 19% for (B), exceeding the goal set at a 5% decrease for both.

Qualitative: Members with 2 or more emergency department visits in a 6 month period are referred to the home health Life Coach program locally or to telephonic case management in the expansion area. All members identified with asthma receive educational mailings, and local members also receive invitations to group education classes. Notification letters are sent to the primary care providers alerting him/her to the home health referral or telephonic case management. These letters include reports on patient utilization for asthma and recommendations on appropriate therapy for asthma patients.

Barriers: There are no case managers in the emergency departments at the hospitals to report asthma admissions in a more timely manner. Early intervention is important to ensure patients are open to receiving asthma education.

Frequently there is no follow up appointment made with the patient's PCP after an acute asthma episode that has required a ED visit.

Telephonic case management is a limited resource that has reached maximum capacity, especially with the addition of more members in the expansion areas.

Opportunity: Patient's are much more receptive to learning about their disease process after suffering from an acute attack. Approaching a patient with educational materials and opportunities post ED visit would assure an increased interest on the patient's part. Making sure the patient schedules a visit with their PCP soon after the ED visit would provide an opportunity for enhanced patient/provider communication and better overall assessment of the patient's asthma.

Intervention: Continue to refer high-risk members to the home health Life Coach program and telephonic case management.

Continue to mail educational materials and invitations to local asthma group education classes.

Notify patient's primary care provider when ED visit occurs.

Encourage ED staff to counsel patient on use of asthma medications and to make a follow up appointment with their primary care provider to obtain ongoing preventative medication prescriptions and an asthma action plan.

Measure #3: Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B).

Quantitative: Because the measure was introduced by HEDIS beginning in 2000, there were no benchmarks for this year. For combined age groups measured (5-56 years) for population (A) the appropriate medication rate was 61.24% for this time period, and for population (B) it was 61.42%. Population (A) exceeded the goal for this measure set at a 5% decrease from the previous year. Population (B) minimally missed the goal. There were no changes to the goals. The percent of appropriate medication use in the previous year for (A) was measured at 56.14% and for (B) was measured at 58.82%. The trend for appropriate use of medication for members with asthma increased for (A) by 8%, exceeding the goal set at 5%, and increased for (B) by 4%, missing the goal set at 5%.

Qualitative: Inservices were provided to some physician practices to encourage appropriate medication prescribing practices and adherence to the National Institutes of Health Guidelines for the Diagnosis and Management of Asthma published in 1997. These guidelines are recognized as the clinical standard for asthma care. Physicians also receive Management Summary reports twice yearly (January and June) to give an overview of how their asthma management techniques compare to their peer group and the goals set by the health system.

Barriers: Although physician practice inservices are well received, they are difficult to schedule due to the busy work environment.

Sentara disseminates guidelines of care, which include asthma guidelines, to all network participating physicians, but many physicians do not take the time to look at these guidelines. This inability to capture physician attention with written material applies also to the individual patient reports and twice yearly management summaries, which are also distributed to the physicians. These tools can not be effective if they are not used.

Appropriate education about the use and purpose of asthma medications often is not imparted to the patient.

Opportunities: Effective medication use can be achieved through improved provider and patient education. Better physician prescribing practices can be encouraged through ongoing educational opportunities and keeping physicians abreast of the newest trends in asthma medications. Better patient adherence to medication regimens can be achieved through ongoing patient education and providing the proper tools to enhance medication performance, such as spacers and peak flow meters.

Intervention: Efforts are being made to reach patients for alternative educational opportunities, such as holding educational seminars at employee work sites. Many members can be reached in this format with the cooperation of their employer. Several of these were held this year in a "lunch and learn" format, which is amenable to both employer and employee.

Attempts will be made to schedule more physician office inservices. There is a need to address not only the physicians within each practice site, but also the office staff who are primarily responsible for performing patient education.

Remeasurement #2: January 1 through December 31, 2001

Measure #1: Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The admission rate for population (A) for this time period was 2.3%, the admission rate for population (B) was 4.6%. Population (A) met the goal and population (B) exceeded the goal set at a 5% decrease from the previous year. There were no changes to the goals. The percent of inpatient admissions for the previous year was measured at 2.4 % for (A) and 4.9% for (B). There was a decreasing trend in inpatient admissions for both populations, improving outcomes for (A) by 4% and for (B) by 8%.

Qualitative: When a member is hospitalized for a primary diagnosis of asthma it is viewed as a failure of treatment, and the patient's current treatment

regimen needs to be reviewed and re-evaluated to see if more aggressive therapy is necessary. All members hospitalized for asthma are automatically referred to the home health Life Coach program in local areas, and members in the expansion areas are referred for telephonic case management. Concurrently the members utilization profile is reviewed and sent to their primary care physicians with guideline recommendations on appropriate medication therapy for asthmatics.

Barriers: Telephonic case management in the outlying areas has been a challenge due to inability to contact members, either through incorrect telephone numbers, disconnected telephone numbers, unreturned messages, or language barriers. These issues are also a concern in local areas where it makes it difficult for the home health nurses to make contact with members referred to the Life Coach program.

Opportunity: The home health Life Coach program has shown positive outcomes in the local population, there is a need to replicate this program in the expansion coverage areas. The telephonic case management program can only be effective if the members contacted are accepting of the service and wish to participate.

Intervention: Contact will be made with home health agencies that Sentara Health Management currently does business with in the expansion areas to find out if any of these agencies would like to participate in providing the Life Coach program in their areas. Also verification of member phone numbers through physician offices will be implemented- often physician offices have more current telephone numbers.

Measure #2: Number of Emergency Department visits for a primary diagnosis of asthma (ICD(493.0-493.92) for populations (A) and (B)

Quantitative: The emergency department visit rate for population (A) for this time period was 10.5%, the emergency department visit rate for (B) for this time was 18.3%. Population (A) did not meet the goal set at 10.3% (a 5% decrease) for this year, however population (B) exceeded the goal of 20.0% with a rate of 18.3%. There were no changes to the goals. The percent of emergency department visits for the previous year was measured at 10.8 % for (A) and 21.2 % for (B). The overall trend in emergency department visits for both populations was downward, with a positive change of 3% for (A) and 14% for (B).

Qualitative: The ongoing interventions of the home health Life Coach program, telephonic case management, educational mailings, and physician reporting seem to be trending emergency department visits downward. All interventions are designed to assist members in self-managing their disease process. With advancements in asthma medication therapy and increased knowledge about the disease process and how to control it's effects, emergency department visits for a primary diagnosis of asthma should be avoidable.

Barriers: There is often a period of time between the actual emergency department visit and when the Disease Management department discovers the visit has been made due to claims processing. Patients are generally more receptive to interventions and disease education directly after an acute episode, therefore timing is important when attempting to educate members about their disease and appropriately accessing health care. The same barriers of member contact continue, with incorrect or disconnected phone numbers being the main problem. There is also an issue of follow up after an emergency department visit, the member is not making an appointment with their primary care physician soon after the ED visit to discuss the cause of the event and possible changes in therapy to decrease the likelihood of another ED visit.

Opportunity: There may be a way to work the emergency department staff of local hospitals to improve notification time of Disease Management when a member is seen for asthma. Another avenue to explore may be to reinforce the use of clinical pathways and standing orders for asthma patients that have been implemented in the Emergency Departments of the local hospitals, ensuring specific educational parameters are performed and follow up appointments are arranged prior to discharge.

Intervention: Educational staff in the emergency departments at area hospitals will be contacted to assess the need for development of a feedback mechanism to Disease Management in a timely manner when a member is admitted to the ED with an asthma diagnosis. They will also reinforce utilization of existing care pathways and standing orders to increase educational opportunities and follow up care while the member is in the ED.

Continuing efforts will be made to verify and update member phone numbers.

An educational website was implemented in October of 2001 with the intent to provide asthma education materials to school health professionals, teachers, students, and parents of children with asthma. The website links directly to other Sentara school health initiatives. It provides clinical tools such as instructions on peak flow meter use, MDI administration, asthma action plans, etc. Along with the educational content, the website provides links to other websites specific to asthma and allergy concerns.

Measure #3: Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B)

Quantitative: The benchmark for population (A) for this year as determined by NCQA's Quality Compass 2001 was QualChoice VA with a combined age percentage of 71.31% appropriate medication use. The Sentara Health Management goal was set at 64.24% for (A) and 63.42% for (B), a 5% increase from the previous year. The actual percentage for appropriate use of medications for combined age groups (ages 5-56) during this time period was measured at 62.53% for (A) and 67.81% for (B). The goal was not met for (A), but was exceeded for (B). There were no changes to the goals. The percent of appropriate medications for members with asthma in the previous year for (A) was 61.24%. The percent in the previous year for (B) was 61.42%. The overall trend of this measure for both (A) and (B) was upward, with a 2% increase for (A) and a 9% increase for (B).

Qualitative: Continuing efforts are being made to inform physicians about updated national and health plan guidelines which recommend the most appropriate medication therapy for asthma patients. Clinical and referral guidelines are created by the health plan and disseminated annually to network participating physicians. Individual patient reports are also sent to primary care providers when a member is identified as having utilization issues either with asthma medications or acute care services. In 2001 the Physician Management Summary was distributed once to network participating physicians. This report gives an overview of several chronic disease states with specific indicators for each disease correlated to the individual physician's patient panel, and comparing their results to that of their peer group and the goals set by the health plan.

Barriers: Barriers to disseminating information to physicians usually involves the communication process. Often, mailed information is triaged by office staff, and may not reach the physician in an appropriate time frame, if at all. Another barrier is correlation between the data the health plan presents to the physician and physician records. The health plan can only record prescriptions filled by the member, but does not have access to prescriptions written by the physician. This discrepancy is usually attributable to patient non-compliance with the course of treatment recommended by the physician.

Opportunity: Enhancing the communication process between the physician and patient and also between the physician and the health plan can lead to better prescribing practices and better patient compliance with medication regimens. Educational opportunities should be presented to both providers and members in an easily accessible fashion to encourage the highest level of participation from both.

Intervention: Continue to distribute Physician Management Summaries and patient specific reports, maintaining as high a level of accuracy as possible. Arrange educational opportunities in environments accessible to both providers and patients. Inservices can be held at physician practice sites, and group education classes can be held at employer sites during lunch hours to encourage participation.

Remeasurement #3: January 1 through December 31, 2002

Measure #1: Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The admission rate for population (A) for this time period was 1.7%, and for population (B) was 4.0%. Both populations exceeded the goal for this measure set at a 5% decrease from the previous year. There were no changes to the goal for this measure. The percent of inpatient admissions in the previous year was measured at 2.3% for (A) and 4.6% for (B). The trend for inpatient admissions for both populations decreased, improving outcomes by 26% for (A) and 13% for (B), exceeding the goal set at a 5% decrease for both.

Qualitative: Ongoing interventions such as the home health Life Coach program targeted specifically to high risk members have proven to be effective in decreasing hospital admissions. There is probably an increased awareness throughout the community about asthma due to the increasing numbers of people being diagnosed with this chronic disease. Educational programs are being provided in the workplace to make attendance more convenient. School

aged children are targeted through educational programs on the schoolasthmaallergy.com website and cable access television programs for local viewers.

Barriers: A growing population of members with asthma in the expansion area presents challenges for contacting members and delivery of services. This is a much more rural population and access to health care is often an issue. There are few organized educational opportunities, and even when these are available, transportation to far away urban areas is not possible.

Opportunity: Education conducted either in the member's home or over the telephone to provide one on one intervention would work best in these more rural settings. Providing mailed educational materials in low reading ability formats and alternative languages, especially Spanish, would also be beneficial. Materials need to be culturally sensitive and every attempt should be made to ensure the member understands the material presented.

Intervention: Home health agencies that provide services in these areas will be contacted to find out which ones are interested in administering the Life Coach program to members in these areas. Once identified, the agencies will be contracted to provide the program, and training will proceed with the agency's staff to begin performing this function. A nurse case manager was hired to provide telephonic case management services to members in these areas. The case manager's responsibilities include mailing educational material, arranging home care services, and telephonic case management for members in the expansion areas. Members can also find educational information through the schoolasthmaallergy.com website if they have computer access.

Measure #2: Number of Emergency Department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The emergency department visit rate for (A) for this time period was 11.6% and for (B) was 20.2%. Neither population met the goal set at a 5% decrease from the previous year. There were no changes to the goal. The percent of emergency department visits in the previous year for (A) was 10.5%, and for (B) was 18.3%. The trend for emergency department visits for both populations increased in 2002. It increased by 10% for (A) and by 10% for (B).

Qualitative: There was an increased effort to provide member education, specifically to reach larger groups of members at one time through educational sessions on site at their workplace, and through participation in health fairs and community outreach programs.

Because the inability to contact members at risk for acute asthma episodes has always been a concern , the issue of telephone verification and identifying accurate phone numbers needs to be addressed.

Barriers: Ongoing barriers include: inability to contact, incorrect phone number, members not interested in participating in the program, member not compliant with recommended therapy, physician not implementing best therapeutic interventions, patient/physician communication issues.

Opportunity: There has not been much progress made in being able to identify members who have had a recent acute emergency department visit. There is still no process in place to notify Disease Management when a member has been to the emergency department. Despite efforts to implement a system with area hospitals, there is no clear indication in the ED of which staff this responsibility would fall upon, and how it should be done for other insurance providers. Also, this would be difficult to replicate throughout the state with the many hospitals members would access.

Intervention: Members are contacted as soon as possible after an emergency department visit to determine level of need and proceed with the appropriate intervention. If the member has been to the ED more than twice in a six-month period they are eligible to participate in the home health Life Coach program in local areas. Members in the expansion areas will be eligible for this service when available in their area. If home health is not available, they will receive telephonic case management. Local members will receive invitations to group classes. All will receive educational mailings. Attempts will be made to continue to provide group seminars at employer sites and participate in community health fairs.

Measure #3: Use of Appropriate Medications for People with Asthma (HEDIS) for population (A) and (B)

Quantitative: The percentage for appropriate use of medications for combined age groups (ages 5-56) during this time period was measured at 66.11% for (A) and 69.62% for (B). The goal of 65.65% for (A) was exceeded, however even with an improvement from the previous year of 2% for (B), the goal

of 71.21% was not met. There were no changes to the goals. The trend for both populations remained positive, with an increase of almost 4% in population (A) and 2% in population (B). The percent of appropriate medication use in population (A) the previous year was 62.53%, and the percent for (B) for the previous year was 67.81%.

Qualitative: Continuing efforts to encourage physicians to prescribe asthma medications appropriately include: dissemination of patient specific reports to primary care physician responsible for patient medication management providing an overview of one year of patient utilization of services and medication use, distribution of clinical guidelines which indicate the recommended appropriate therapy for asthma patients, letters to physicians outlining recommended therapy and suggesting changes to patient prescribing practices. Members also receive information on medications they are using along with an explanation of what control medications are and how to use them. Patients are encouraged to discuss any questions or concerns they may have about their medication with their physician.

Barriers: There has been some reticence on the part of pediatric primary care physicians to use inhaled steroid based medication with younger patients. The NIH re-issued their guidelines decreasing the age deemed appropriate for use of inhaled steroids to 4 years of age, in some cases even younger. This information needs to be relayed to the pediatric physicians, along with encouragement to put younger children with persistent forms of asthma on these types of medications as prevention against asthma attacks.

Opportunity: Promoting good communication between patient and physician is the key to appropriate self- management of a chronic disease process such as asthma. Sometimes the patient can act as a catalyst to trigger a change in how the physician chooses to manage their disease process. Through education of both patient and physician in the best possible treatment of asthma, the goal is to improve the appropriate prescription and use of preventative asthma medications by both physicians and patients.

Intervention: Continue various avenues of both patient and physician education. Make physicians aware of changes in age considered appropriate for use of inhaled corticosteroid medication. Help patients to understand the safety of this type of medication through mailed information and telephonic case management. Encourage good patient/physician communication channels through written and telephonic interventions.

Remeasurement #4: January 1 through December 31, 2003

Measure #1: Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The admission rate for population (A) for this time period was 2.3% and for population (B) was 4.4%. Neither population (A) or population (B) met the set goal for this time period. The percent of inpatient admissions in the previous year was measured at 1.7% for (A) and 4.0% for (B). There were no changes to the goal for this measure. There was a minimal increase for both populations in this measure, with inpatient admissions increasing by only 2% in population (B).

Qualitative: Members who have been admitted to the hospital with a primary diagnosis of asthma are classified as high risk and are automatically enrolled in the home health Life Coach program. This program has been expanded to include coverage areas throughout the expansion areas of Virginia, and is now available to almost all member service areas. This program continues to encourage better self-management techniques such as improved medication utilization, trigger identification and avoidance, and good physician/patient communication techniques. The schoolasthmaallergy.com website is available to members with access to reinforce educational materials and provide additional resources within Sentara and in the member's community. The asthma case manager contacts members to provide educational services and guidance over the phone.

Barriers: A continual barrier to providing services is lack of telephone and incorrect demographic information. All outreach techniques are dependent upon being able to speak to the member to impart the educational message and inform them of services available. Sometimes it is possible to verify telephone numbers through the physician offices, however this becomes time consuming and labor intensive for staff to contact individual physician offices for member telephone numbers.

Opportunity: Because telephonic communication is not always an option, written communication mailed to the member needs to become a focus as it may be the only way available to make contact with the member. Letters will be sent to all members unable to be contacted on the telephone explaining why they are being contacted and asking them to contact Sentara if possible. Educational materials are already being mailed to all members identified with asthma. These materials provide written educational information when one on one information can not be performed.

Intervention: Increased attempts will be made to encourage participation in the home health Life Coach program for all members. Telephone numbers will be verified by Disease Management staff and correct contact numbers will be forwarded to appropriate home health agencies. The asthma case managers will make contact with all high risk members to inform them of the Life Coach program and let them know they should expect to be contacted by a home health nurse to set up appointments in their homes. Case managers also mail letters to members who cannot be contacted by phone to ask the member to contact Sentara in order to participate in the program. Case managers have the ongoing responsibility of mailing educational packets to all members identified with asthma in the health plan.

Measure #2: Number of Emergency Department visits for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The emergency department visit rate for this time period for population (A) was 10.7% and for population (B) was 22.3%. Population (A) met the set goal of 11.0%, population (B) did not meet the set goal of 19.2%. The goal set for this year did not change from the 5% decrease set in previous years. The percent of emergency department visits in the previous year for (A) was 11.6% and for (B) was 20.2%. There was a 10% decrease in emergency department visits for population (A), and a 5% increase in emergency department visits for population (B).

Qualitative: Efforts are ongoing to improve the education of members to seek medical attention at their primary care site as opposed to using the emergency room whenever possible. This message is being disseminated in several ways throughout health plan communications to members. They are reminded in enrollment information, when they access member services on the phone, and through member handbooks. They are encouraged to call the After Hours nurses during off- hours and seek medical advice through this avenue rather than proceed to the emergency department.

Barriers: Patients tend to view the emergency room as a place to receive immediate care even if their health issue is not urgent. Often it is a matter of proximity and timing that makes the emergency department easier to use than the primary care site. They are also guaranteed to be seen the same day even with a long wait, rather than having to make an appointment and possibly having to wait a day or two to be seen by a doctor.

Opportunity: There is a need to use various forms of communication to encourage patients to use appropriate treatment sites. Reiterating this message in multiple forms of patient contact will continue to inform members of the necessity of using good judgement when deciding how to seek medical attention when necessary.

Intervention: Multiple levels of patient education will continue to address this issue. Members being seen in the emergency department for a primary diagnosis of asthma more than twice in a year will be placed in the home health Life Coach program. Part of the education within the program includes tips on when to seek emergent care. The Life Coach nurses are available 24 hours around the clock for questions or concerns regarding asthma, as are the after hours nurses. Members are also eligible for telephonic case management, as well as educational mailings. All forms of communication stress the importance of seeking emergent care responsibly.

Measure #3: Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B)

Quantitative: The percentage of appropriate medication for combined age groups measured (ages 5-56) for this time period is 68.81% for population (A) and 68.24% for population (B). Both groups fell below the goals set at 69.41% for (A) and 73% for (B), which were set at a 5% increase from the previous year percentage increase. There were no changes to the goals. The percent of appropriate medications for members with asthma in the previous year for (A) was 66.11% and for (B) was 69.62%.

Qualitative: The National Institutes of Health updated their guidelines for management of asthma in 2002. These updates include recommending the use of inhaled corticosteroids in younger children, generally ages 4 and above. 500 of these updated guidelines were sent out to participating primary care and

pediatric physicians identified as prescribing high amounts of rescue medicines with low amounts of preventative medicines. Letters are sent to physicians along with individual patient utilization reports, making them aware of their prescribing practices on an individual patient level. The letter also reminds physicians of the NIH guideline recommendations for prescribing preventative medicines for anyone diagnosed with a persistent form of asthma.

Barriers: Communication to physician practices needs to be reinforced through written and oral communication. Not all written communication is viewed by the physician, oral communication is the best way to make sure the message is received. Other avenues of communicating this message need to explored and implemented. There also continues to be a need to reinforce patient education about the over use of rescue medicines and the need to control asthma symptoms through increased use of preventative medicine. There is still a misperception about the detrimental nature of corticosteroids, and many patients also quit using their preventative inhaler because they feel no immediate relief from this type of medication.

Opportunity: The use of other entities besides health plan resources can be employed to communicate the need to increase the use of preventative medications. Representatives from pharmaceutical companies can reach physician office and staff to educate on this issue, as well as having other physicians comfortable with the topic present to physician peer groups. Educating the patient about the benefits and safety of inhaled preventative medicines can lead to increased requests for the physicians to prescribe these types of medications.

Intervention: Take advantage of contacts outside the health plan to increase awareness of the updated guidelines and safety of prescribing inhaled corticosteroids in younger children. Include pharmaceutical representatives, outside coalition contacts, local and national resources (American Lung Association), instruction from other physicians. Encourage patients to communicate severity of symptoms and need for ongoing preventative medication to their physician to help physicians understand the level of asthma severity and the need for prevention rather than just rescue medicines.

Remeasurement #5: January 1 through December 31, 2004

Measure #1: Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The admission rate for population (A) for this time period was 1.7% and for population (B) was 4.1%. Both population (A) and population (B) met the goals set at 2.18% and 4.18% respectively. The percent of inpatient admissions in the previous year was measured at 2.3% for (A) and 4.4% for (B). There were no changes to the goal for this measure. The trend for inpatient admissions for both populations was a decrease, improving outcomes by 26% for (A) and by 7% for (B), exceeding the goal of 5% improvement set for both.

Qualitative: The home health Life Coach program continues to be the focus for intervening with the highest risk asthma members who have had to be hospitalized for their asthma. This program consistently shows positive outcomes for participating members, with fewer hospitalizations for a primary diagnosis for asthma. Case managers continue to perform outreach phone calls to members who are accessing health care services frequently, and who have a sub-optimal medication utilization profile. Every member identified with a diagnosis of asthma receives educational mailings with contact numbers to reach an asthma case manager if they have questions or concerns about their disease. Efforts to improve patient contact rate, especially in the Optima Family Care population, include contacting physician offices to access the member's most recent demographic information.

Barriers: Barriers to providing disease management services have not changed throughout the course of the program's existence. Correct patient contact information is continually an issue. Also, there are still members who do not wish to participate in the program, even after it is explained that the program is of no cost to them, that the service is provided in their home so transportation is not an issue, and that disease management staff are a available to them as an additional resource whenever they need them.

Opportunity: Because some members are not open to the idea of having a health care worker come to their home, it may be more advantageous to encourage them to participate in the telephonic case management program, or to access educational opportunities within their community. Members are referred to their physician office, local hospital information line, or local branches of organizations dedicated to pulmonary health to find out if there are any community based educational opportunities in their area. If a patient does not wish to participate in the home based program, they will be contacted by

a case manager via telephone to provide educational services.

Intervention: High-risk members will be encouraged to participate in the home based Life Coach program through mail and telephone contact. Asthma case managers will make contact with all high-risk asthma members when possible to explain the program and it's benefits and encourage participation. The case managers will also encourage participation in any other educational opportunities available in the member's community. They will discuss the member's concerns about program participation and answer any questions the member may have regarding the program that may prohibit their participation. The member will also continue to receive explanatory letters in the mail, which will also encourage program participation.

Measure #2: Number of Emergency Department visits for a primary diagnosis of asthma (ICD 493.0-493.92) for populations (A) and (B)

Quantitative: The emergency department visit rate for this time period for population (A) was 10.5% and for population (B) was 20.7%. Population (A) did not reach the goal set at 10.17% , however population (B) achieved a lower emergency department visit rate than the goal of 21.18%. The set goal did not change. The percent of emergency department visits in the previous year for (A) was 10.7% and for (B) was 22.3%. There was a 2% decrease in emergency department visit rate in (A) and a 7% decrease in (B).

Qualitative: Continued efforts are being made to educate members to contact their physician during office hours for non-emergent medical situations. Members are also educated about the necessity to treat their asthma in a timely fashion and not wait until symptoms have progressed to the point where emergency care is necessary. Members are advised about the availability of asthma case managers during the day, after hours nurses evenings, nights, and weekends, and the home care Life Coach staff if they are enrolled in that program. They are encouraged to contact these clinical resources to help assess their situation and the need for medical intervention.

Barriers: Patients continue to view the emergency room as a quick and convenient source of medical care. They understand they will not be denied care if they have a medical problem. Most patients who use the emergency department frequently know they will receive medical attention for their problem at a time and place that is convenient for them. Because their medical problem is resolved at the visit they continue to go back.

Opportunity: There has been a concerted effort for many years by the health plan to educate members as to when it is appropriate to seek emergent care. It is difficult to make these guidelines applicable to every individual case; therefore there is still uncertainty among members as to when it is appropriate to go the emergency room. Life Coach staff develop a care plan with the high-risk members which outlines the specific signs and symptoms they need to be aware of when it would be appropriate for them to go to the emergency department. There is an opportunity to broaden this activity to all asthma members who are contacted by an asthma case manager. Case mangers could work with their patients to develop action plans to assist the patient in self management of their disease and knowing what action to take based on their symptoms a peak flow meter readings.

Intervention: Educate home health Life Coaches and asthma case managers on the importance of developing an asthma care plan for all members they work with. Have the patient discuss this care plan with their physician to make sure the physician agrees with actions to be taken. Asthma educators should make sure all patients have peak flow meters and may supply them to the patient when necessary. When possible the asthma action plan should be developed in conjunction with the patient's peak flow meter readings. Asthma action plans can also be based on patient symptoms if a peak flow meter reading is not available (smaller children, elderly adults who may not be able to use the device.).

Measure #3: Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B)

Quantitative: The percentage of appropriate medication use for combined age groups measured (ages 5-56) for this time period is 71.70% for population (A) and 67.66% for population (B). Both groups fell below the goals set at 72.25% for (A) and 71.64% for (B). These goals were set at a 5% increase from the previous year percentage increase. There were no changes to the goals. The percent of appropriate medication use for members with asthma in the previous year for (A) was 68.81% and for (B) was 68.24%. Although goals were not met, the trend of the data remained positive for population (A), with a slight decrease for population (B).

Qualitative: Physicians receive medication information through numerous sources, including medical journals, pharmaceutical industry publications and

representatives, internet sources, etc. Optima Health informs physicians of recommended treatment guidelines for multiple health conditions through yearly publication and distribution of Clinical Guidelines. This publication includes guidelines for the care and treatment of asthma based on the recommendations of the National Institutes of Health guidelines. Although the guidelines address physician prescribing practices, it is also important to educate the patient on using their medication appropriately. There is often an issue with patients discontinuing use of their asthma control medications because they feel better and think it is no longer necessary to take their medication. An integral part of patient education should include reminders of the purpose of the control medication and to continue to take it as their doctor recommends until otherwise directed.

Barriers: Patients as well as physicians must be educated on the appropriate use of the medications they are prescriibed to treat their asthma. One of the more common findings of the asthma case managers and Life Coach staff is that a control medication is prescribed, but the patient discontinues use when they begin to feel better, or they get more short term relief from their rescue medication, therefore choosing to use it frequently rather than the control medication.

Opportunity: The development of an asthma control plan with the patient can address not only issues around emergent care, but also reiterates the every day actions the patient should take to treat their asthma. All recommendations should be in conjunction with therapy as suggested by the patient's physician. All medications prescribed to the patient should be listed on the control plan, along with dosage and frequency information. This care plan should be kept in an easily accessible location so the patient can refer to it quickly and conveniently.

Intervention: Focus on both patient and physician education relative to importance of developing and following an asthma action plan. A form for an action plan is included in all mailings to patients, and the patient is encouraged to either take the action plan along on a doctor visit to have the physician complete, or contact an asthma case manager at the health plan to assist in completing and then take to their physician for approval. Also stress the importance of following recommendations for asthma therapy on the action plan, especially the use of daily control medications.

Remeasurement #6: January 1 through September 30, 2005

Measure #1: Number of inpatient admissions for a primary diagnosis of asthma (ICD9 493.0-493.92) for populations (A) and (B)

Quantitative: The admission rate for population (A) for this time period was 1.7% and for population (B) was 4.0%. Population (A) did not meet the goal set at 1.61%, however population (B) did meet the goal set at 4.0%. The percent of inpatient admissions in the previous year was measured at 1.7% for (A) and 4.1% for (B). There were no changes to the goal for this measure. The trend for inpatient admissions for both populations was minimal if any change, with no relative change in outcomes for this measure for this time period from the last measurement.

Qualitative: As stated in prior analyses, the home health Life Coach program continues to be the focus for intervening with the highest risk asthma members who have had to be hospitalized for their asthma. This program consistently shows positive outcomes for participating members, with fewer hospitalizations for a primary diagnosis for asthma. Case managers continue to perform outreach phone calls to members who are accessing health care services frequently, and who have a sub-optimal medication utilization profile. Every member identified with a diagnosis of asthma receives educational mailings with contact numbers to reach an asthma case manager if they have questions or concerns about their disease. Efforts to improve patient contact rate, especially in the Optima Family Care population, include contacting physician offices to access the member's most recent demographic information.

Barriers: As in analysis from previous years, barriers to providing disease management services have not changed throughout the course of the program's existence. Correct patient contact information is continually an issue. Also, there are still members who do not wish to participate in the program, even after it is explained that the program is of no cost to them, that the service is provided in their home so transportation is not an issue, and that disease management staff are a available to them as an additional resource whenever they need them.

Opportunity: Optima continues to explore alternative methods for improving member contact and increasing participation in disease management interventions. Various other health care organizations and coalitions throughout communities in Optima's coverage areas provide asthma education in

different settings, including community centers, doctor offices and schools. There is a need to identify and partner with these education providers to have multiple resources for members to access to obtain asthma education.

Intervention: Contact has been made with several local asthma coalitions and community service providers to develop partnerships in asthma education. One community provider has had a successful relationship with Optima's high-risk OB program, improving member contact rate and providing educational and social services as needed to these members. Optima would like to expand on this partnership to include pediatric members with asthma.

Measure #2: Number of Emergency Department visits for a primary diagnosis of asthma (ICD 493.0-493.92) for populations (A) and (B)

Quantitative: The emergency department visit rate for this time period for population (A) was 9.6% and for population (B) was 20.7%. Population (A) achieved better than the goal set at 10.0%, while population (B) did not quite meet the goal set at 19.7%. There were no changes to the goals. The percent of emergency department visits in the previous year for (A) was 10.5% and for (B) was 20.7%. There was a 6.3% decrease in the emergency department visit rate for (A) and no change in (B) from the previous year.

Qualitative: Continued efforts are being made to educate members to contact their physician during office hours for non-emergent medical situations. Members are also educated about the necessity to treat their asthma in a timely fashion and not wait until symptoms have progressed to the point where emergency care is necessary. Members are advised about the availability of asthma case managers during the day, after hours nurses evenings, nights, and weekends, and the home care Life Coach staff if they are enrolled in that program. They are encouraged to contact these clinical resources to help assess their situation and the need for medical intervention.

Barriers: Members seek treatment for acute asthma episodes in the emergency room and obtain relief from their symptoms. Because they no longer are having symptoms from their asthma, they often do not follow up with their PCP to monitor their condition and receive maintenance therapy for their asthma.

Opportunity: Continue to educate members through multiple written and telephonic interventions about appropriate use of the Emergency Department. Use as many sources as possible to enhance member's knowledge about when it is necessary to access emergent care and when it is appropriate to make an appointment with their PCP. Continue to encourage the member to schedule follow up appointments with their PCP after an acute episode requiring emergency care.

Intervention: Continue to provide member education material outlining correct process for accessing emergent care. Focus asthma home health and case management staff on reminding members and physicians of importance of an Asthma Action Plan to assist members in knowing what to do when they have an asthma exacerbation. Encourage members to obtain and use peak flow meters to better assess status of asthma and treat more proactively.

Measure #3: Use of Appropriate Medications for People with Asthma (HEDIS) for populations (A) and (B)

Quantitative: The percentage of appropriate medication used for combined age groups measured (ages 5-56) for this time period is 68.97% for population (A) and 68.69% for population (B). Population (A) did not meet the goal set at 71.7%, but population (B) achieved better than the goal set at 67.66%. There were no changes to the goals as set from previous time periods. The percent of appropriate medication use for members with asthma in the previous year for (A) was 71.70% and for (B) was 67.66%.

Qualitative: As stated in previous analyses, continuing efforts to encourage physicians to prescribe asthma medications appropriately include: dissemination of patient specific reports to primary care physician responsible for patient medication management providing an overview of one year of patient utilization of services and medication use, distribution of clinical guidelines which indicate the recommended appropriate therapy for asthma patients, letters to physicians outlining recommended therapy and suggesting changes to patient prescribing practices. Members also receive information on medications they are using along with an explanation of what control medications are and how to use them. Patients are encouraged to discuss any questions or concerns they may have about their medication with their physician.

Barriers: Many new asthma medications have been introduced in the past several years. Each of these medications can have different indications for use,

it is important that physicians are prescribing them for the appropriate patients, and that patients are using them as they are intended to be used. It often takes time for providers and patients to be aware of newer medications and to begin prescribing them when indicated.

Opportunity: Provide members and physicians with updated guidelines that include most recent information on pharmacotherapy for asthma. Monitor prescribing practices to ensure that physicians are prescribing medications to the best advantage of the patient. Make sure the patient is optimizing recommended therapy before prescribing newer alternative medications.

Intervention: Optima has developed guidelines for physicians to recommend appropriate therapy according to severity level of patient's asthma. These guidelines are disseminated yearly to participating physicians, and are updated yearly to include all newer modalities of treatment.

Interventions Taken for Improvement as a Result of Analysis- Note: Interventions taken across all Lines of Business- no differences in interventions will be listed for Commercial/POS and Family Care members.

Ongoing Interventions Implemented Prior to Analysis Cycles for Current Review:

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers Interventions Address
01/97	X	Asthma Home Health Program instituted for all members with asthma classified as high risk based on service utilization, self-reported symptoms, physician identification, and pharmacy utilization. Program focuses on home-based education and environmental assessment, with ongoing follow up for pediatric members as long as they participate in the health plan. Adult members are re-assessed after one year for need to continue in the program. Home Health nurses are trained in asthma education including: peak flow meter use, MDI with spacer use, identifying triggers, environmental assessment, appropriate medication use, and Asthma Action Plans.	Barrier: Encouraging member education, participation in self-management of disease process This program was developed to address the need for intensive, ongoing education of asthma management techniques. It was determined that little or no education was being addressed in the physician office, and that there was a need to consistently reinforce asthma education to maintain patient compliance with recommended treatment protocols.
05/97	X	Group classes were begun for all members with asthma in the local Hampton Roads, Va. area. These classes provide basic asthma education including: peak flow meter use, MDI with spacer use, identifying triggers, appropriate medication use and Asthma Action Plans. The classes are held twice monthly in the evening, and all members identified with asthma receive an invitation to attend and a class schedule.	Barrier: Member education for less severe asthma patients. These classes were designed to give members with less severe asthma an opportunity to learn more about their disease process. The group setting is conducive to encouraging communication between people who suffer similar symptoms and experiences, providing positive feedback and more willingness to achieve treatment goals.

08/97	X	Clinical Guidelines for treatment of asthma were developed and distributed to network participating physicians. The guidelines were developed by a team of physicians lead by the program physician leader, and based on the National Institutes of Health Guidelines for the Diagnosis and Treatment of Asthma. These guidelines are updated at periodic intervals to reflect any recommended changes in asthma care.	Barrier: Physician education, notification of updated information for best practice. The guidelines were developed to assist physicians in maintaining optimal care for their asthma patients. They were designed to provide the physicians a quick and easily accessible overview of asthma patient management.
02/98	X	Physician reports were developed which include indicators for the physician receiving the report, the physician peer group, and goals established by the health plan. These indicators include the number of members in that physician's panel who have had inpatient admissions and emergency department visits, and the medication ratio of beta2-agaonists to anti-inflammatory inhalers for the members in that physician's panel.	Barrier: Physician education, physician awareness of self-practice and goals and expectations pertaining to asthma. It was determined that physician's often were not aware of the overall status of their patient's utilization patterns. This report provides the physician with a quick overview of important indicators for several chronic disease processes to encourage optimum patient care.
02/98	X	A report that shows all prescriptions filled for asthma related medications by individual member was developed. This report also includes a breakdown of medications prescribed by physician.	Barrier: Physician education, physician awareness of patient compliance with recommended treatment The development of this report enabled the Disease Management staff to better identify members who were not using appropriate medication therapy for asthma and provide intervention such as the home care program or telephone case management. It also provided additional information to physicians to further assist them in increasing appropriate prescribing practices for their asthma patients.
07/98	X	SHM implemented Welcome Calls to new members. Included in the general information obtained during these calls it was ascertained if the new member had ever been diagnosed with asthma. This information is forwarded to the Disease Management staff for further action.	Barrier: Identification of members to provide education in a timely manner Implementing the Welcome Calls gives SHM the opportunity to address any concerns about a members asthma immediately upon their enrollment, rather than waiting for them to file a claim or fill a prescription for identification purposes.

07/98	X	Educational booklets began to be mailed on an ongoing basis to any member identified with asthma. These booklets contain an overview of all pertinent information for asthma education. They were designed at a low literacy level to be appropriate for all members. Two books are sent out, one for adult members with asthma and one for parents of pediatric asthma members.	Barrier: Patient education, knowledge of disease process to enhance self-management. The books were developed as a method of communication with members who were not eligible for other more intensive interventions, or not able to attend scheduled classes.
Interventions For Analysis Cycle January1 through December 31, 2000			
01/00	X	Physician Management Summary reports were sent to physicians participating with the health plan and who had a minimum of 10 patients in their panel diagnosed with asthma. These reports gave the physician an overview of three parameters pertaining to care of their asthma patients: Number of patients with asthma, hospital admissions, ED visits, and medication ratio.	Barrier: Physician education, personalization of asthma data. This tool allows physicians to see not only how the health plan measures their performance for specific chronic disease conditions, but also allows them to measure their performance against their peer group of physicians and the goal established by the health plan.
02/00	X	An asthma education videotape was distributed to the Sentara Hospitals in the Hampton Roads area. This video is to be run several times a day on the hospital education system, which is provided on the televisions in patient rooms. Each patient receives a schedule for this station while they are in the hospital, and the hospital staff is encouraged to have the patient who have been admitted with asthma watch the tape while they are in the hospital.	Barrier: Patient education, disseminating information while patient is experiencing an acute episode. This intervention was developed to reach patients while they are in the hospital . Because asthma patients are more likely to want to learn about their disease and how to avoid severe episodes after having suffered through a recent attack, it is a good opportunity to have them watch and learn while they are in the hospital. This intervention will affect all SHM members who are admitted to any Sentara Hospital.
03/00		Conducted a large group mailing to 1580 children identified with asthma between the ages of 6-12.	Barrier: Patient education, providing information to a select age group often at risk for acute asthma exacerbations. Mailing was designed to inform and educate children of a specific age group to be more aware of asthma and how to treat it. Encourages self-management techniques.

05/00		Article included in member newsletter reminding members of the availability of the asthma program and providing tips on how to avoid triggers in "prime" asthma allergy season	Barrier: Patient education, patient awareness of programs and how to access for participation. Incidence of asthma attacks are usually higher in spring and fall, articles designed to target asthma sufferers when symptoms are worse.
06/00	X	Physician Management Summaries re distributed to participating physicians.	Barrier: Physician education.
07/00-08/00		3 Camp Superkids day camps were held in the Hampton Roads area. Children between ages 6-12 participate in a day of education and activities geared towards enhancing their knowledge about asthma.	Barrier: Patient education, children and parents participating in the care of the disease. This intervention is designed to encourage young asthmatics to learn more about their disease and take an active roll in managing their symptoms. It is intended to address the growing population of asthmatics in this age group and introduce the concepts of self-management to promote compliance at an earlier age.
08/00		Article published in member's quarterly magazine about asthma disease management. Article included comments from a family with a child who participated in the home care program and had a very positive experience with the program.	Barrier: Patient education, making members aware of available programs and how to participate. All materials published and distributed to members that include information on the Disease Management programs enhance member knowledge about the availability of the programs and what the intended outcomes and benefits of participation are.
10/00-12/00		Provided inservices on asthma management to three network physician practices and their staff. Gave updated information on the asthma disease management program, reviewed National Institutes of Health Guidelines for the Diagnosis and Management of Asthma, and gave copies of Sentara Health Management's Clinical Guidelines book.	Barrier: Physician education, encouraging awareness of updated best practice guidelines. This was done to increase awareness in the practice setting of the need to use optimum prescribing practices for asthma, educate patients on how to manage their disease, and increase awareness of the programs offered through Sentara to assist the physicians in achieving the goal of best practice for asthma management.
Interventions for Analysis Cycle January 1 through December 31, 2001			

01/01		Developed a Disease Management team to implement the BCAP Typology for Asthma and Diabetes specific to the Family Care (Medicaid) population. This group worked to identify barriers to providing these services to the Family Care members and develop solutions that could be put into place easily and in a short amount of time.	Barrier: Family Care member education, how to enhance communication between members and the health plan, and between divisions within the health plan. This intervention was developed to address the issues and concerns specific to the Family Care population, such as: inability to locate members to provide services, disconnected phones making contact difficult, and children missing days from school due to asthma. It also addressed internal communication issues between Family Care and Disease Management.
01/01	X	Began a telephonic case management program for members identified with moderate asthma in the Hampton Roads area and members with both moderate and severe asthma identified in the Central Virginia expansion area. The asthma educator maintains contact at weekly intervals initially, with decreasing frequency over time as specific educational goals are met. When all goals are met the member is discontinued from the program. Members can be re-entered into the program if they revert back to having acute episodes and seeking emergent medical care.	Barrier: Home Health program not cost effective for moderate risk members, but they are in need of more contact to possibly stop progression of the disease to more severe. It was determined that there was a need to increase intervention level with members designated as moderate asthmatics, because they have the potential to become severe asthmatics if there disease is not managed appropriately. Because there is no home care intervention available yet (agencies are being contracted with to provide this program in these service areas) in the Central Virginia expansion areas, there was a need to provide a greater level of intervention to members in this area.
02/01	X	Through work with BCAP Disease Management team, a series of questions specific to asthma were constructed that were added to the Family Care Intake Screenings. The Intake Screenings are questionnaires that the Family Care field representatives ask new members in a face to face interview to get an overview of the needs and health issues a new member might need to have addressed. These screenings are forwarded to the appropriate disease management department when a member indicates a diagnosis of one of the chronic diseases. The member is then risk stratified according to how the questions were answered and available data, and the appropriate intervention taken.	Barrier: Patient education, identification of new health plan members with asthma. This addresses the need to identify new members with asthma quickly and intervene when necessary to insure continuity of care for their asthma when they join the health plan.

02/01-09/01		Presented asthma education classes on site to three large group employer groups, with participation by 162 members.	Barrier: Patient education, need to take education to the member in a convenient location and optimal time. Enables members with asthma or dependents with asthma to receive necessary education at a convenient time and place.
04/01		Patient education materials were revised to reflect recent advances in treatment modalities for asthma patients.	Barrier: Patient education. Addresses the necessity of keeping patients informed and providing them with the tools necessary to promote self - management of their disease.
07/01	X	Physician Management Summaries were mailed to network participating physicians.	Barrier: Physician education Summaries are an ongoing effort to improve physician knowledge of their patient's utilization trends and pharmacy indicators for asthma.
09/01		A repeat mailing of educational materials to 2600 members with asthma between the ages of 6-12 was completed.	Barrier: Patient education, address needs of younger members with asthma. Mailing was designed to inform and educate children of a specific age group to be more aware of asthma and how to treat it. Encourages self-management techniques.
10/01	X	Officially launched schoolasthmaallergy.com website. The website provides information about asthma and allergies geared towards school nurses. It also contains information pertinent to teachers, parents, and children with asthma. The website contains educational tools and information, and also provides links to other sites and organizations that provide health related information.	Barrier: Patient education, develop alternative ways of patient outreach. The website was developed to reach out to the growing number of members who access the internet to obtain health information. It was determined that this was a medium that was found in almost all schools and could be easily accessed by the nurses to download information that would be useful in taking care of their students with asthma.

Interventions for Analysis Cycle January 1 through December 31, 2002			
01/02		Participated in a School Health Fair at a local high school. The health fair was intended to promote fitness and health education for high school students. Over 500 students and faculty attended the health fair. Asthma educational sessions were held throughout the day, with educational materials available for distribution upon request.	Barrier: Patient education, reaching out to younger members to encourage self-management techniques, taking education to a convenient location at a convenient time. There is a continuing need to promote awareness of asthma and increase compliance and self-management. Members in the high school age group historically have a low compliance rate with suggested treatment, the health fair was a way to address members who may not avail themselves of other forms of asthma education.
02/02		Provided clinical expertise for a cable access television program sponsored by the Norfolk Public School system. The television show addresses topics of interest for students in the public school system. A panel of high school students participated in the broadcast; asking questions about asthma that they felt were pertinent to teens suffering from this chronic disease. Questions and answers were interspersed with educational information and demonstrations of peak flow meters and MDI with spacer use.	Barrier: Patient education, reaching large amounts of members at one time. This was another avenue to provide needed education to an age group that is not always compliant with treatment, or would usually seek out educational opportunities about their disease process.
03/02		Conducted an asthma education session on site for 35 members of a large group employer.	Barrier: Patient education, convenient time and place Enables members with asthma or dependents with asthma to receive necessary education at a convenient time and place.
04/02		Reviewed and revised After Hours Nurse protocol for asthma. Updated medication lists to reflect latest changes in National Institutes of Health Guidelines.	Barrier: Health plan staff education, updating information to provide optimum care for members with asthma. After Hours nurses receive phone calls from members with asthma, they need to be aware of the appropriate intervention to suggest for the member and to stay current in the latest trends in asthma care.

05/02	X	Worked with Sentara Family Care to have their staff verify telephone numbers of Family Care members referred to the Home Care Program. Family Care staff will try to provide most accurate phone number as possible, may contact physician office to verify most recent number.	Barrier: Patient education, ability to contact member to provide needed education. A major barrier to enrolling Family Care members into the Home Health Asthma Program was the inability of the home health nurses to contact the member to set up an appointment. Verifying phone numbers will increase the number of members contacted and participation in the program.
05/02	X	Worked with the IT staff to develop a report to accurately reflect the members who are enrolled in the Home Health Asthma program each month.	Barrier: Health plan information, ability to track members in need of services, or already receiving services in order not to duplicate efforts. SHM was dependent on the Home Health staff to report back to us which members that were referred to the Home Health Asthma Program actually got admitted to the program. The communication was sporadic and not provided in a timely fashion. The development of this report enables the Disease Management staff to track accurately which members are enrolled in the home care program and when they are admitted.
05/02		Participated in a health fair conducted by a large group employer. Over 600 health plan members attended the health fair. Educational information about asthma was distributed to interested members, and demonstrations of peak flow meter use and MDI with spacer use were conducted. Individual education was conducted upon request.	Barrier: Patient education, ability to reach large numbers of members at a convenient time and place. This health fair provided an opportunity to reach out to members in a convenient location. These members may not have otherwise sought out information for their disease. It was an effective way to reach a large group of people at one time and maximize efforts to provide asthma education.
08/02	X	Physician Management Summaries distributed to network participating physicians.	Barrier: Physician education These reports are an ongoing effort to keep physician's in touch with their patient's utilization of services and give them additional information to assist them in providing optimal care for their patients.

10/02	X	Hired a nurse case manager to oversee the expansion area asthma and diabetes populations. This case manager will be responsible for telephonic case management of moderate and high risk asthmatics (where home health Life Coach program is not available), referral to home health programs where available, and mailing educational information to all identified asthmatics in these areas.	Barrier: Patient education, enhancing outreach to members in expansion area. With a growing number of members in non-local areas, it was important for Sentara Health Management to be able to provide the same level of asthma education and disease management intervention to all members. The nurse case manager will provide enhanced services to outlying areas and complement the Life Coach program.
Interventions for Analysis Cycle January 1 through December 31, 2003			
4/03		Participated in interview s with a consulting firm (The Lewin Group) hired by the Environmental Protection Agency to provide information about the home health Life Coach program. The EPA chose Sentara's Asthma Disease Management Program to participate in developing a guide book for other Managed Care organizations instructing them on how to develop their own disease management program. These programs would place a great deal of emphasis on the importance of incorporating environmental management into asthma outreach, education, and management strategies.	Barrier: Inability to duplicate these types of programs in all areas, inability to provide home visits within the program structure to provide environmental assessment of the home. The EPA felt that Sentara's program had the necessary focus on this aspect of asthma management to highlight the program on a national level. This program can be used as a template for a successful Disease Management program.
5/03	X	Inserviced staff at UVA Continuum Home Health on all aspects of the Life Coach program. Developed a communication process to guarantee a quick, smooth referral and feedback process between Sentara and the home health agency. This agency will begin providing the Life Coach program to high- risk asthma members in a large service area of central Virginia.	Barrier: The barriers to this program have always been inability to locate/contact members. This may be a greater consideration in the areas covered by this agency as it will be a largely rural population. The agency has agreed to make multiple contact tries to members referred. The asthma case managers will try all possible avenues of contact to ensure accurate contact numbers for the home health agency.

5/03		Staff from all Disease Management areas attended a Wellness Fair for employees of a large group insured by Sentara. This Wellness Fair was attended by over 1500 employees. Educational materials were available for members interested in learning more about their disease process, and a survey was taken by those wishing to participate. This survey provided information about the member's asthma symptoms and was used as an additional resource in identifying and risk stratifying members for the program.	Barrier: Participating employees had a limited amount of time to access a large amount of information. Not all members attending had the opportunity to gather information they needed or was pertinent to their needs. These large group venues for disseminating information about disease states and available programs are beneficial forms of outreach. Allowing the members more time to gather information specific to their needs would be an important consideration for future health fairs.
5/03	X	Presented updated Clinical Guidelines for Asthma to the Physician Advisory Committee. These updated guidelines reflected changes made to the national guidelines developed by the National Institutes of Health, which lower the age for safe use of inhaled corticosteroid medications to treat persistent forms of asthma in all age groups.	Barrier: Changing physician prescribing practice to reflect new guidelines. Communicating new guidelines to physicians. Guidelines were approved by PAC members and distributed to all participating physicians. Additional national guideline updates were mailed to primary care and pediatric physicians identified through prescription data as having prescribed large amounts of rescue medicines and low amounts of preventative medicines.
6/03	X	Worked with pharmacy personnel to develop criteria for determining appropriate members for the new asthma drug Xolair. Physicians requesting this medication for Sentara members must complete a form outlining these criteria and only members meeting the criteria will be approved for reimbursement. All members requesting this medication must participate in the home health Life Coach program for ongoing monitoring of adherence to good disease management techniques	Barrier: This drug is only effective in a select group of asthma members with a highly allergic form of the disease. Its use in other types of asthma patients would not be appropriate. Physician awareness of this fact is crucial to its appropriate use. The criteria developed by the health plan are designed to ensure only appropriate candidates are considered for this medication, and to guide physicians in choosing patients who would benefit from this drug.

8/03	X	Inserviced staff at Mid-Atlantic Home Health in the Richmond area on all aspects of the Life Coach program. Developed a communication process to guarantee a quick, smooth referral and feedback process between Sentara and the home health agency. This agency will begin providing the Life Coach program to high- risk asthma members in a large service area of central Virginia.	Barrier: The barriers to this program have always been inability to locate/contact members. This may be a greater consideration in the areas covered by this agency as it will be a largely rural population. The agency has agreed to make multiple contact tries to members referred. The asthma case managers will try all possible avenues of contact to ensure accurate contact numbers for the home health agency.
8/03		Participated in filming a Video News Release sponsored by the Environmental Protection Agency in conjunction with the American Association of Health Plans. The Life Coach program was chosen out of 20 possible candidates from across the nation to be featured in this video news release. A camera crew filmed one of the asthma home health nurses conducting an actual visit in the home of a member with asthma. The goal of the VNR was to show how important controlling environmental factors and good education are key to better asthma management. The VNR aired on 96 television stations across the U.S., reaching approximately 4.1 million viewers.	Barrier: None This method of reaching out to a national audience further enhanced the program's ability to reach large numbers of individuals and disseminate the message that proper asthma management can be the key factor in decreasing symptoms and living a normal life for asthma patients.
10/03	X	The annual analysis of the Asthma Home Health Life Coach Program showed positive results for all lines of business in outcomes indicators. The analysis showed a 56% decrease in inpatient admissions for participating members when comparing pre-program data to post-program enrollment data. There was also a decrease of 22% in emergency department visits in the Life Coach participating members pre and post enrollment. The Medicaid population specifically had a 44% decrease in inpatient admissions pre and post enrollment, and a 15% decrease in emergency department visits.	Barriers: Ongoing barriers to this program include lack of correct address/telephone numbers, lack of interest on the member's part to want to participate, members not completing the program, dropping out before the curriculum is completed. Many of these barriers are difficult to overcome. Sentara is seeking to partner with other organizations throughout the state to improve the rate of participation, especially with Family Care members. These organizations are grant-funded coalitions, which could provide access to the Medicaid population through neighborhood ambassadors (community lay-workers) and provide some minimal asthma education as well as a gateway into the member's home that wasn't there before. Sentara is also seeking grant funding to further these efforts of using community based lay-workers to enhance the capture rate of members in need of these services.

Interventions for Analysis Cycle January 1 through December 31, 2004			
01/04		Met with nurse practitioners from several pediatric practices to educate them about the program, how to refer patients, and discuss criteria for which patients are appropriate to refer. Discussed suggestions on how to improve knowledge about the program within physician practices both locally and throughout the state. Also discussed best ways to communicate patient information between the disease management staff and office staff. Each office had different communication needs ranging from e-mail to fax to telephone.	Barrier: Communicating program specifics and referral information to multiple physician practices in a large geographic area. Many different methods have been used to educate physician practices about the program and encourage patient referral. Mailed materials often do not reach their intended source, or get opened if they do. Articles have been published multiple times in provider newsletters, but these do not always get disseminated to office staff who would be making the referrals. The nurse practitioners felt that reaching out to office staff through presentations and mailings would be the best way to encourage referrals of appropriate patients to the program.
4/04		Participated in a workshop sponsored by the Center for Health Care Strategies (CHCS) designed to brainstorm ideas to add value and implement changes within the program. The focus was on reaching out and successfully engaging members who were difficult to contact or reticent about participating in the program.	Barrier: Increasing number of asthma members participating in the various program interventions. There are multiple reasons for lack of participation in the program. Primarily in the Medicaid population there are issues with incorrect demographic information and lack of desire to participate. The idea was suggested during this session that it would be beneficial to use outreach workers from the community to locate and intercede with these difficult to reach/engage members and encourage program participation. This idea will need further planning and budget considerations before implementation.

06/04	X	Contracted with Home Care Alliance of Virginia to provide home health Life Coach throughout the state. Even though there were multiple home care agencies contracted with all over the state, there were still some coverage areas not being serviced for the Life Coach program. Home Care Alliance is an oversite body comprised of multiple home health/DME companies across the state. They will disseminate referrals for the Life Coach program to agencies in the appropriate coverage area. This will streamline the referral process, condensing the need for communication back and forth to just one agency.	Barrier: There are still small gaps in home health Life Coach program coverage areas, and it was necessary to track multiple home care provider sites with different staff qualifications and paperwork. By contracting with just one company to provide this service, the coverage area has expanded and there is more consistency in communication and feedback. It is only necessary to work with one agency, providing consistency in staff education, paperwork, and communication process.
07/04		Received a request from the chief medical resident at Sentara Norfolk General Hospital to provide an in-service for the medical residents at the hospital about asthma innovations and medications. Spoke to a group of approximately 15 residents, providing them with educational material and discussing all aspects of asthma education.	Barrier: There are few opportunities to provide asthma education opportunities to doctors in training. This was an excellent opportunity to address this group of newly practicing physicians and provide input into their training process concerning the treatment of asthma. The intent was to insure that they were aware of the newest treatment modalities and to give them insight into the difficulties they may encounter when treating these patients and how to overcome these difficulties.
08/04 – 12/04	X	Requested to present asthma patient education classes at a local community health clinic serving a largely Medicaid insured or uninsured pediatric population (Peninsula Institute for Community Health).	Barrier: There is consistently a need to educate members of this population in a way that is easy to understand and in a place that is convenient for the patient. Having monthly patient education classes at this clinic site has provided an opportunity to address patients who do not always have transportation to other asthma education opportunities. Hopefully having one class each month will provide an opportunity to reach different patients each month.

09/04		Presented an inservice about the new injectible asthma drug Xolair to community and hospital case managers. Reviewed the criteria that patient's must meet in order to be eligible for this drug. Also reviewed the referral process and contact numbers for the case managers to enable them to refer an appropriate patient to the program.	Barrier: There are always questions about new medications when they first become available, and it is important to educate the people who will be coming into contact with asthma patients about which patients this drug is intended for and what criteria must be met. This inservice was an opportunity to educate health care professionals about this new medication, which patients will benefit most from it, and what indications each patient must have to be approved for it. It was also a good opportunity to review the referral process for the home health program and make sure all appropriate contact information was up to date.
12/04	X	Presented an inservice to Respiratory Care staff at three local hospitals regarding the asthma program, who is eligible, and how to refer patients when appropriate. This will be done biannually to reach out to new hires each year.	Barrier: Patients who are hospitalized for asthma are most receptive to learning about their disease after an acute episode has recently occurred. There is an opportunity to have faster referrals to the program for hospitalized patients if the hospital staff notify the program upon a patient's admission for asthma. By educating the respiratory staff on the referral process and providing them with the appropriate contact information, it will be easier to contact the patient in a more timely fashion and take advantage of that window of opportunity when they are most willing to receive education about this chronic disease process.
Interventions for Analysis Cycle January 1 through September 30, 2005			
2/05	X	Developed collaborative strategy with Optima Family Care marketing staff to implement health awareness community workshops in coverage areas throughout the state. These workshops will focus on selected health issues such as asthma, diabetes, cardiovascular health, and pregnancy that have been determined to affect the Medicaid population. The workshops will be set up by and communicated to the members through Optima Family Care marketing staff. Educational services for the workshops will be provided by Disease Management clinical staff. Implementation will begin in the upcoming months.	Barrier: Past experience has shown that it is difficult to get large numbers of members to attend group education sessions. The Optima Family Care marketing staff will target specific members identified with the disease chosen as the topic of discussion with mailings and phone calls to encourage participation. They will also provide gifts and food to members who attend. Members who have issues with transportation will be assisted in getting to the workshops when possible.

3/05	X	Hired a full time asthma case manager to contact moderate and high-risk asthma members in expanded coverage areas. Previously there had been a part-time case manager dedicated to this population. This will result in an increased ability to establish patient contact.	Barrier: Even with an increase in case manager hours it will still be difficult to establish contact with all moderate-risk asthma members in the health plan. There is a plan to further increase staffing by hiring a Patient Advisor Representative to screen asthma members, risk stratify according to symptoms and utilization, and forward only members in need of additional case management services to the case managers. The PAR would also be responsible for general mailings.
5/05	X	Implemented an electronic charting tool called E-case, which enables all case management staff throughout Disease Management and Medical Care Management to keep electronic record of member contacts and communicate case information to each other in a timely and accurate fashion.	Barrier: Training process for new system is time consuming. All staff need to be trained on the tool, and remember to use the tool when charting member contacts. Certain staff members were designated as trainers for the tool. Each staff member went through the training process. Periodic updates are provided through one on one communication or e-mail to remind staff of correct process and procedure. As the tool is upgraded and changes made, training sessions are provided to maintain knowledge base.
8/05	X	Entered into discussions with statewide home health care service provider (CHIP- Children's Health Involving Parents) that uses community outreach workers to provide education to specific members. This organization currently provides services for the high-risk OB program and has been very successful in contacting members and monitoring them during their pregnancy. The goal is to use this program to increase the number of members with asthma that are contacted and ensure that they receive necessary education.	Barrier: It is still difficult to keep track of accurate demographic information, making it a challenge to contact and maintain an ongoing relationship with members who need disease management intervention. Because this organization utilizes outreach workers that live within the communities they serve, they often have a clearer picture of how to locate members. They are also more aware of any socio-economic issues that may be an impediment to optimum medical care for these members.

8/05	X	Participated in a web conference sponsored by the Environmental Protection Agency to discuss Optima's Asthma Disease Management program and ways to enhance program outcomes with other health plans that wish to implement similar types of programs. Optima was selected to participate in this conference because of being one of the winners of the EPA's National Environmental Leadership Award in Asthma Management. This award was presented to Optima in May 2005 to reward the ongoing achievements of the program in improving the care of it's members with asthma.	Barrier: Not all health plans have the same types of organizational structure or technology systems that would enable them to duplicate this type of program. Although exact duplication may be difficult, it would not be necessary in order to achieve positive outcomes. Each organization needs to assess the systems they have available and determine if they have the ability to add to their existing systems to enable them to create a program that meets the needs of their members.